AIDS Population and Health Integrated Assistance Project

USAID/Kenya

REPORT OF THE MID-TERM REVIEW

Barbara Dickerson

Mid-term Review Team Leader

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LIST OF ACRONYMS

ABEO	(USAID/Kenya) Agriculture, Business and Environment Office
AFS	APHIA Financing and Sustainability (Project)
AIDS	Acquired Immune Deficiency Syndrome
AIM	AIDS Impact Model
APHIA	AIDS, Population and Integrated Assistance
BCC	Behavior change communications
BDI	Bungoma District Initiative
CA	Cooperating agency
CAFS	Center for African Family Studies
CBD	Community-based distribution
CHAK	Christian Hospital Association of Kenya
CII	Contraceptive Independence Initiative
CS	Child Survival
CYP	Couple-Years of Protection
DANIDA	Danish development agency
DFH	Division of Family Health (now Division of Primary Health Care)
DFID	Department for International Development (formerly ODA)
DG	Democracy and governance
DHMB	District Health Management Board

DHMT	District Health Management Team
DPHC	(MOH) Division of Primary Health Care (formerly Division of Family Health)
DSHC	Division of Strategic Health Communications
DTC	Decentralized training center
EU	European Union
FP	Family planning
FPAK	Family Planning Association of Kenya
FPLM	Family Planning and Logistics (Project)
FY	Fiscal year
GOK	Government of Kenya
GTZ	German Technical Cooperation
HCF	Health Care Financing
HIV	Human immune deficiency virus
IEC	Information, education and communication
IR	Intermediate Result
IUD	Intra-uterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JHU/PSC	Johns Hopkins University Population Communication Services
JICA	Japan International Cooperation Agency
JSI	John Snow International
KANCO	Kenya AIDS NGO Consortium
KDHS	Kenya Demographic and Health Survey
KEMRI	Kenya Medical Research Institute
LMU	Logistics Management Unit (MOH)
M&E	Monitoring and evaluation
MOH	Ministry of Health
MSCU	Medical Supplies Coordinating Unit
MSH	Management Sciences for Health
MTR	Mid-term Review
MYWO	Maendeleo ya Wanawake Organisation
NASCOP	National AIDS and STI Control Programme
NCPD	National Council on Population and Development
NGO	Non-governmental organization
OSPP	(USAID/Kenya) Office of Strategic Planning and Participation
PHC	Primary health care
PSI	Population Services International

REDSO/ESA	USAID regional office for East and Southern Africa
RH	Reproductive Health
RHTC	Rural health training center
RTI	Research Triangle Institute
SDP	Service delivery point
SIDA	Swedish International Development Association
SO	Strategic Objective
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TA	Technical assistance
UNICEF	United Nations Childrens Fund
VII	Vaccine Independence Initiative
VSC	Voluntary surgical contraception
WHO	World Health Organization

EXECUTIVE SUMMARY

BACKGROUND

The AIDS, Population and Health Integrated Assistance (APHIA) Project was designed to consolidate all USAID support to the population and health sector in Kenya under a single, integrated strategy. APHIA was approved in August 1995 as a five-year, $60 million results package. In January 1999, APHIA was extended at a level of $135 million over 10 years. The purpose of the project was identical to the Mission's Strategic Objective #3 (SO#3) *to reduce fertility and the risk of HIV/AIDS transmission through sustainable, integrated family planning and health services*.

APHIA provides support to three main program areas where USAID has made considerable, continuous, and successful investments:

- Family Planning (FP) since 1972,
- HIV/AIDS since 1989, and
- Health Care Financing (HCF) since 1989.

APHIA also provided for a new initiative in child survival that focuses on a single pilot district, the Bungoma District Initiative (BDI) that began in 1997.

While APHIA was designed to take advantage of synergies between these program areas, it was also budgeted at a lower level than had been in effect in preceding years. Before 1995, funding for the health sector in Kenya had averaged roughly $20 million annually. Under APHIA funding has declined to about $13 million annually:

	FP	AIDS	HCF	BDI+	TOTAL
Pre-APHIA	$15m	$3m	$2m		$20
APHIA	$ 7m	$3m	$2m	$1m	$13

ACCOMPLISHMENTS UNDER APHIA

Even with this reduced level of funding, there have been notable gains in each of the major program areas:

Family Planning: Between 1983 and 1998, modern contraceptive prevalence among married women has more than tripled from 10 to 32 percent, among the most rapid, sustained increases in the world. Among African countries, only South Africa and Zimbabwe have higher prevalence. Due principally to this increase in prevalence, the total fertility rate (TFR) has fallen dramatically over the past 20 years, from an estimated 8.1 to 4.7 children per woman between 1976 and 1996. This 40 percent decline in fertility helps to ease the pressures of population growth on Kenya's society, economy and environment.

HIV/AIDS: While the epidemic is expanding, there are signs that sexual and reproductive attitudes and behavior are changing. Nearly all reproductive age women and men have heard of AIDS and roughly 85 percent know at least one way of avoiding infection. Nearly 40 percent know at least two of the four important ways of avoiding infection. Among men, nearly 50 percent know that condoms can be used to avoid AIDS, up from 36% in 1993. And 90 percent of men report that they have changed their behavior in some manner to avoid AIDS, with 50 percent limiting sex to one partner, 20 percent using a condom, and 15 percent abstaining from sex. Among women, 77 percent report that they have changed their behavior, with 47

percent limiting sex to one partner, 3 percent using a condom, and 19 percent abstaining from sex.

Health Care Financing: There have been marked increases in revenues generated through cost-sharing activities, growing from under $US 1million in 1990 to $4million in 1993 to over $8million in 1998. This initiative has been critical to increasing the sustainability and improving the quality of public health services. It has also been a cornerstone of national health reform as it has worked to devolve authority and accountability in public health to the district level. This initiative has also lent support to the privatization of two major hospitals and the sustainability of health NGOs through shared-risk insurance.

These gains are particularly commendable given that the APHIA program has been operating at funding levels reduced by one-third.

REASONS TO CONTINUE USAID SUPPORT

But continued progress in these areas is by no means assured and continued investments by USAID is key to future progress in this important sector. The following are the key reasons to continue funding these program areas:

Increased cohorts entering their reproductive ages: Since 1980, the number of women in their reproductive ages has more than doubled. The size of the reproductive age population will continue to grow markedly in the years ahead. This means that the number of contraceptive users will need to grow by 3% each year just to maintain current contraceptive prevalence. This also translates to greater numbers each year potentially exposed to the risks of HIV infection – such that activities aimed at AIDS prevention must expand 3 percent annually just to keep pace with this growth, let alone expand coverage.

Unmet need for family planning: Despite the remarkable growth in family planning use in Kenya, 24 percent of currently married women express an unmet need for family planning – wishing to limit or space their next birth but remaining exposed to pregnancy. There is a clear need for continued expansion of access to quality family planning services.

Expanding HIV/AIDS epidemic: HIV/AIDS prevalence among adults has increased from 5 percent in 1993 to 9 percent in 1997. In almost all sentinel sites in Kenya, the rate of HIV prevalence continues to increase. HIV infection is most common among young adults with girls and young women at greatest risk. This is a particularly difficult group to reach, since most health systems are oriented toward adult clients and there remains a resistance among some quarters to providing condoms and other contraceptives to youth. Growing numbers of people each year enter reproductive age and are exposed to the risk of infection. Because the illness caused by the virus strikes people in their most productive years, the epidemic threatens the stability and prosperity of Kenyan society.

Child mortality increases: Recent surveys indicate a worsening of child mortality rates during the 1990s, following decades of steady declines. Between 1989 and 1998, under-five mortality rates have increased by 25 percent. These reversals are most dramatic in Nyanza province, and there are equally substantial increases found in Coast, Eastern and Rift provinces. These increases are thought to be due to the expanding HIV/AIDS epidemic in combination with malaria, known to be on the

increase and other diseases, since child immunization rates have also fallen throughout this period.

Increased demands for health care: The continued growth of reproductive age population in Kenya, combined with increasing HIV prevalence and child morbidity assures that the demands on the health care system in Kenya will grow rapidly in the years ahead. Experience with public sector health care financing and social marketing indicate that when available at affordable prices, Kenyans are willing to pay for health care. Since public sector health resources are not increasing, building and strengthening cost-recovery systems, including expanding services through private sector providers, are essential if programs are to be able to keep up with demand.

USAID strengths in the public health sector: USAID has supported activities in this sector in Kenya for more than 25 years – and so has a significant investment that could largely be lost if assistance does not continue. USAID has proven technical leadership and a comparative advantage in the major areas of APHIA support, including family planning, HIV/AIDS, and health care financing. Finally, the strategic objective of APHIA is consistent with USAID sector objectives for stabilizing population growth and protecting human health.

Other donor support: Over the past ten years, other donors have stepped up their assistance to Kenya's public health sector. For example, contraceptive commodities, once supplied almost exclusively by USAID, are today supplied almost exclusively by other donors. Contraceptive contributions from other donors over the past four years amount on average to more that $6 million per year. Other donors have also provided other supplies and commodities beyond contraceptives, including condoms. They have provided complementary support for reproductive health (RH) information and services, including providing support to some local organizations that have been reduced in funding under APHIA and directly supporting a number of US cooperating agencies (CAs). Current funding for APHIA is about two-third of the level foreseen in the project design. To a significant extent, funds from other donors have replaced rather than supplemented USAID funding. As donors have faced significant difficulties working through the public sector at the national level, support has in many cases shifted toward NGO channels or toward district level activities. The prospects for future donor funding are not encouraging. Despite the growing needs for RH/HIV information and services in Kenya, future donor assistance to the health sector is static or, in some cases, decreasing.

Relevance for other countries in the region: Kenya plays an important role in the east Africa region, serving as a major economic and transportation hub. In the public health sector, the Kenya program has been the locus for developing many innovations that have been diffused to other countries in the region, with contraceptive logistics and health care financing being just two examples. In family planning, Kenya has been among the earliest successes in all of Africa and continues to be looked to as an example to other countries. Diffusion of new ideas for behavior change with respect to family planning and HIV/AIDS prevention can also be shared across borders. In the effort to stem the HIV epidemic in eastern Africa, Kenya will play an important role given its size and influence in the region. So success in Kenya's public health sector does and can continue to have impacts that reach beyond its borders.

GAPS AND CONSTRAINTS

The mid-term review team noted several gaps and constraints which will impede progress in achieving APHIA objectives.

Contraceptive prevalence: The contraceptive prevalence rate, 23.6 percent among all women according to the 1998 Kenya Demographic and Health Survey (KDHS), falls far short of the target of 32.8 percent The rate of uptake has slowed, thus making it unlikely that the goal of 38% contraceptive prevalence by 2000 will be met.

Couple-Years of Protection (CYP) targets for USAID-funded programs: CYPs fell short of expected targets for USAID funded programs. Reasons for this appeared to be closely tied to programmatic decisions taken due to the APHIA budget cuts. Community-based distribution (CBD) programs were cut back drastically including reductions in numbers of CBD agents, cuts in training and supervision. Some of the shortfall may be due to under-reporting as well.

Integration of CS/HIV/AIDS/FP services: USAID has promoted integration of services in traditional MCH/FP service sites through information sharing, training and research. Findings from the mid-term review, however, show that integration of reproductive health services has not taken hold to the extent envisioned in the APHIA design. APHIA documentation itself does not present a consistent definition of reproductive health. In the field, the integration of services for prevention of HIV/AIDS and other sexually transmitted infections (STIs) in family planning clinics is limited. While training and curricula development for service providers have taken place under APHIA, there are still many who have not been adequately prepared to provide STI services and have reservations about discussing sexual behavior with clients. The child survival portfolio is also not well integrated into the project and functions more as an adjunct activity.

Slow pace of implementing health sector reforms: The Ministry of Health developed a plan for restructuring the central ministry in 1996. This plan has still not been implemented three years later. Many aspects of the reform agenda have been tackled but the process has not really moved forward. The main constraint to date has been the lack of the requisite senior management team to drive the reform process.

The lack of strong leadership and drive for the process has been felt most in the service delivery system. Financing and management of public facilities at the service level is deeply troubled everywhere – at the district, provincial and central levels. A great deal more needs to happen in decentralizing the allocation of government resources. Public sector primary health care appears to be deteriorating in many parts of the country. The private sector is expanding rapidly, but in an unregulated manner. This in turn raises serious questions about general quality of care.

Risks associated with the expansion of services in the private sector: The private sector is providing more reproductive health services compared to five years ago. The possibility for supervision and oversight of private practitioners from the government is limited. As the private sector begins to provide an increasing share of clinical services such as intra-uterine device (IUD) placement or post-abortion care, the risks of infections and post-procedural complications are a possibility which cannot be ignored.

Questions about the quality of training: There are still numerous problems within the MOH training and supervisory system. Emphasis still tends to be on numbers of trainees rather than trainee performance. Supervisors are not adequately trained.

There is insufficient financial and logistical support for carrying out effective supervision. Authorities have not been well defined.

Guidelines and standards have been developed but not effectively disseminated or utilized. A national Reproductive Health Training plan has been developed but there is no plan or commitments as yet for putting it into effect.

Training does not appear to have been effective in instilling the fundamental skills and attitudes needed for services providers to function as effective advocates for informed choices and behavior change that result in better reproductive health for their clients. Many of them have reservations about discussing sexual behavior with clients – particularly with adolescents – and thus may provide condoms only to clients with STIs. In the face of the rapidly expanded AIDS epidemic, it is irresponsible to provide a family planning method to a female client without also counseling on the need to ensure dual protection.

There continue to be glaring inequities and inefficiencies in the system for incentives and promotion. Decisions about who is trained and where personnel are deployed are still frequently driven by favoritism and other factors which do not relate to individual qualifications and needs within facilities.

Barriers to behavior change in the face of the growing social and public health disaster posed by the rising AIDS epidemic: Respondents frequently expressed the opinion that behavior has basically not changed. The seemingly high level of knowledge and awareness about AIDS hides the extent of ignorance that still exists. There is also denial of personal risk and lack of internalization and personalization of the dangers of HIV. Cultural practices and norms, including gender issues and power relations, reinforce the barriers to change (particularly to condom use). These norms include adult attitudes towards youth from parents, church leaders, and health providers. The weight of these influences together with the lack of commitment from leaders across many levels of Kenyan society conspire to continue Kenyan society's denial of the socio-economic and personal impact of the epidemic.

Limited access of adolescents to services for family planning, STD prevention and control: Adolescents constitute a large segment of the population. Investment in improving their chances for a healthy future also safeguards the future for the country. Improving access in clinical facilities and making them more youth friendly is but one side of the problem. Another side is that adolescents are not frequent visitors to clinics, and thus efforts to reach them in other ways are equally important. There has to be a continued effort to influence attitudes on the part of parents, church leaders, adults in general who continue to be unable or even unwilling to consider the realities of adolescent sexual behavior. In greatest need of services are female adolescents, at risk for both HIV infection and for the dangers associated with pregnancy at a young age.

Other gaps in demand for basic health services: There is much evidence of failure to provide Kenyans with information about basic reproductive and child health services and convince them to use these services. A large share of Kenyan women have received no pre-natal care by the sixth month of pregnancy. About one-third of family planning users discontinue a method within twelve months of starting; many among them stop because of concerns about side effects or adverse effects on health. More than 80 percent of non-users of family planning have neither been visited by a CBD agent nor contacted about family planning during a visit to a health facility. A growing number of children are not being brought in for vaccinations.

Lack of appreciation of the importance of women and children in Kenyan society: Efforts to promote continued reduction of fertility and risk of HIV/AIDS transmission must be underpinned by promoting a fundamental respect for the contribution of women and children toward the prosperity and future well-being of Kenyan society. There is a widespread lack of this in the current Kenyan societal context.

Other constraining factors in the broader socio-economic context for fertility reduction and risk of HIV/AIDS transmission: Economics and education ultimately figure as two of the most important determinants of fertility choices and child survival, and there are causes for concern. With GNP growth and agricultural production slowing and a population growth rate of more than two percent, the prospect of seems to be growing that families will increasingly face the choice between eating or paying for basic health care and school fees.

Limitations in various approaches for delivering services - the role of clinics versus CBD (and other outreach) services: CBD programs account for a small percentage of all family planning methods. These programs are expensive but are also an effective way to reach persons living in remote areas. The fact that the population of Kenya is still predominately rural is a reason to consider that CBD programs for the near future at least could still be considered as an effective, if expensive, way to reach people living in more remote areas. There are still questions to be answered about effective ways to structure CBD programs.

Supply of necessary supplies and commodities: Reliable sources for condoms, other contraceptives, STI drugs, other essential drugs and vaccines do not exist and futures donations are uncertain. Kenya faces serious deficits in contraceptive supplies over the next five years. This is particularly critical regarding future supplies of condoms. Neither the donors nor the GOK have a clear strategy to secure reliable sources of these supplies for the long term.

Funding from other donors: The health sector in Kenya relies heavily on donor contributions. Future donor funds are not likely to rise. Some donors are closing programs in Kenya, others plan to maintain present level of funding or decrease funds altogether.

RECOMMENDATIONS

Build on USAID's existing strengths and experience: The mid-term review team agreed unanimously that this should be an over-arching principle underlying APHIA programming through the year 2005. APHIA should continue to build on 20 years of successful USAID experience in delivering family planning services. This includes systems for supporting service delivery: training, policy and advocacy, IEC, commodities and logistics.

Adopt a geographic focus: This would entail identifying target districts within a limited number of provinces, two or three at most. Although specific districts would be targeted, the overriding perspective is a community-based approach. The interventions would focus on service delivery for reproductive and child health. This includes supporting systems such as policy, commodities management, training, IEC and advocacy for recognition of the rights of women and children.

In addition attention would also paid to the community context, that is to say all the important determinants of fertility and risk of HIV transmission – education economic status (of households and communities), along with any other important societal and cultural determinants. These factors should be closely monitored and while APHIA

would not directly address all of these needs, it should be prepared to ensure that somehow these needs are addressed. This could take several forms:

Co-programming with other donors

Co-programming with other offices within the USAID/Kenya mission (food security programs with ABEO or democracy and governance (DG) grants with the Program office)

Advocacy with district and provincial officials to ensure that problem areas are identified and receive priority for programs and funding.

APHIA assistance would support activities at all levels: community, district, provincial and national. The idea is to ensure that referral facilities at the district and provincial levels function adequately to support communities and that management teams at all levels are technically capable of providing oversight and guidance for RH and child health activities within the communities. A community-based approach would be used to inform policy formulation at the national level and be documented for the purpose of replication throughout the country.

In brief, APHIA through the end of 2005 would look much like it did in the original design – with the components for IEC and district focus reintroduced. It is no longer possible for APHIA to continue to try to be a national program given the present funding constraints and the ever-present possibility of more funding cuts. Though the program at the national level would look much the same as it does now, this would mean that cooperating agency (CA) programs would be supported only in specified geographic focus areas.

Advocate within the mission to adopt a geographic focus across all programs: The possibilities for co-programming have been referred to above. It may not possible to maintain 100% congruence of geographical targeting across all programs. USAID/Kenya could consider setting targets within the various offices once geographic areas are agreed upon. This would mean that ABEO and DG agree to concentrate a fixed percentage of its activities in focus areas.

Continue to work with the GOK to move the process of implementing health sector reforms forward: USAID should collaborate with other donors and the Ministry of Health in the preparation of the Health Sector Strategic Plan. USAID should also collaborate with other donors and the Ministry of Health to develop a plan of action for strengthening the management capacity of the Ministry's reform team, including senior central and provincial managers, headed by the Permanent Secretary that will drive all aspects of the reform process.

USAID should also continue working on cost-recovery and community financing initiatives drawing from successful models developed elsewhere. USAID should use experience at the community level to inform the process of setting policies and procedures at the provincial and national levels.

Work with the GOK to maintain quality control as service delivery expands in the private sector: This entails working with the MOH as it refines the regulatory framework for oversight of service delivery in the private sector.

Integrate child survival interventions more concretely into APHIA and focus on the child rather than on interventions: Introduce indicators which focus on benefits to child beneficiaries – such as immunization rates and, if feasible, infant and child mortality. Define targeted age groups. Continue district-level IMCI with focus on malaria and get communities more involved in understanding IMCI and

implementing IMCI at the household level. Continue to focus on the Vaccine Independence Initiative (VII).

Continue to work with the MOH to address issues related to training: Facilitate the development of a stakeholders group in support of training to share information and avoid duplication of effort. NASCOP should be included in this group. Consider ways to better operationalize the training information management system. Consider making the need to aggressively confront the selection and deployment process a conditionality in the next agreement mechanism. Support a study to analyze effectiveness and efficiency of various training methods now being explored under APHIA. Focus more attention on skills training for supervisors. Support training which is aimed at changing provider attitudes and practices which limit access to health care and information.

Reinstitute IEC as a strong APHIA project component and broaden to include additional messages to support improved reproductive health: Revive the IEC working group among USAID funded CAs as a means to establish more coherence in IEC activities. IEC should be recast as behavior change communication to emphasize a focus on behavior change interventions based on interpersonal communication. However, mass media and audio-visual materials should continue to be used where appropriate. Social marketing techniques should be more integrated into IEC processes. APHIA should consider emphasizing a basket of IEC messages which go beyond RH to include child health and other determinants of fertility and risk of HIV transmission. Examples of this would be: Keep children (especially girls) in school. Encourage younger adolescents (both boys and girls) who have not yet become sexually active to abstain and those who have become sexually active to protect themselves against HIV/AIDS and other STIs. Encourage dual protection against pregnancy and HIV/AIDS. Encourage women to seek antenatal care and full immunization coverage for their children. Advocate to reduce cultural barriers which impede the access of women, children and adolescents to basic health care.

Revisit CBD programs and examine potential for adapting successful models from other countries: Explore the possibility for broadening CBD programs to a community outreach program which encompasses RH and child health. CBD agents sometimes cover areas of up to 200 households. It is not reasonable to expect volunteers to effectively cover this many households. USAID should undertake a study to assess relative cost-effectivness of various CBD models undertaken in Kenya to date and make suggestions based on experiences of other models in Asia and Latin America.

Commodities: Undertake a study to get an independent determination of national requirements for RH commodities. Use this study as the basis for developing a national strategy that can address long- and short-term scenarios and propose solutions.

Project management USAID should consider ways to reduce the number of CAs working in training and service delivery. USAID should take a stronger role in coordinating training activities to avoid duplication of effort and encourage CAs to share information on processes and tools for assessing performance of trainees. USAID should also take a stronger coordinating role in service provision and encourage CAs to cut back geographic scope of activities rather than cut support for supervision.

Project monitoring and evaluation: USAID should revisit the following targets and indicators:

Capacity building in the private sector: Settle on an indicator which best describes impact of work in the private sector.

CPR targets: Review the original underlying technical assumptions and try to assess and quantify factors contributing to the slowdown in CPR.

CYP targets for USAID grantees: Develop realistic new targets. Consider the possibility that as the HIV epidemic expands, condoms may comprise a rapidly growing share of CPR. CYP targets may have to be revised accordingly.

National CYP targets: CYP targets could be affected if the program moves to increased emphasis on condoms. Although national CYP is on track, there is some evidence pointing to a possible slowdown. USAID should examine this further.

More effective method mix: A more effective method mix generally refers to long-term or permanent methods. This objective needs to be balanced against the reality of a rapidly rising HIV prevalence and the call for “dual protection” which may entail increasing emphasis on condoms.

Impact of HIV/AIDS activities: If USAID decides to adopt a geographic focus, explore the feasibility of using data on incidence to report on impact of HIV/AIDS activities at the district (or provincial level).

Generally USAID should revisit the results framework to include more emphasis on impact to beneficiaries This includes disaggregation of data by age and gender.

USAID should also consider undertaking an interim household survey, between KDHS, to assess progress toward achieving desired impact for project beneficiaries and to monitor other socio-economic factors related to fertility and child survival.

I. INTRODUCTION AND BACKGROUND

The AIDS, Population and Health Integrated Assistance (APHIA) Project was designed to consolidate, focus, and rationalize all USAID support to the population and health sector in Kenya. APHIA was approved in August 1995 as a five-year, $60 million results package. In January 1999, APHIA was extended at a level of $135 million over 10 years. The purpose of the project was identical to the Mission's Strategic Objective #3 (SO#3) *to reduce fertility and the risk of HIV/AIDS transmission through sustainable, integrated family planning and health services*.

USAID/Kenya believes that significant progress has been made under the APHIA project. The 1998 KDHS shows that the impressive reduction in fertility is continuing. The total fertility rate in Kenya has dropped from eight in the late 1970s to 4.7 by 1998. Most of this decline was due to the increased use of modern family planning methods by Kenyan couples. Among currently married women, the contraceptive prevalence rate (CPR) for modern methods has increased to 31% in 1998, up from 7% in 1977. Condom sales increased dramatically in 1998 and important AIDS policy issues are beginning to be addressed.

However, the KDHS shows that important challenges remain. Kenya still has a large unmet demand for family planning services and existing services are not evenly distributed throughout the country. HIV/AIDS also presents a major challenge to Kenya's health, economic, and social sectors. Adult HIV seroprevalence has risen from 3.5% in 1990 to more than 9% in 1998. Finally, after decades of decline, child mortality is beginning to rise, probably due to malaria and AIDS and to problems in the delivery of health care.

Historical Background

USAID has supported Kenya's family planning program since 1972. By the mid-1980s USAID was the lead donor, providing an average of $17-$20 million annually through bilateral and central projects. During the early 1990s, USAID continued to be the lead donor in family planning and provided one-quarter of HIV/AIDS prevention program expenditures. It was also the largest source of support to the national health care financing program. Through 1994, USAID/Kenya's health and population program consisted of four bilateral projects, 15 contracts and cooperative agreements with U.S. organizations, and sub-grants with 41 private sector organizations. And 25 Kenyan NGOs.

In 1994, USAID/Kenya began the design of the five-year $100 million APHIA project. However, in 1995, as APHIA design was nearing completion, USAID/Kenya received sharp budget cuts which required the Office of Population and Health (OPH) to develop both high ($9.3 million) and low ($6.3 million) budget scenarios. Under both scenarios, explicit support to family planning service delivery, as well many other program elements, including research, IEC, the district focus, and the HIV/AIDS program, was dramatically reduced. In reaction to these cuts, USAID elevated its emphasis on sustainability. Sustainability was defined in APHIA as "support to strategies and programs which build Kenya's capacity to sustain health and family planning services and meet *future* needs with local resources."

Considerations for the Mid-term Review (MTR)

With APHIA funding currently at about $12 million, OPH felt the need to re-examine emphasis areas and current programmatic directions. Many of USAID's cooperating agencies (CAs) providing technical assistance in Kenya under the previous bilateral

project continued to undertake similar activities under APHIA. USAID wished to review their direction and accomplishments, and examine implementation and management options, before providing further support.

The results of the 1998 KDHS have raised concerns about child survival and infectious diseases. There are also new opportunities to promote or socially market more effective family planning methods and other commodities. In addition, there is increased impetus to focus on adolescent reproductive health, post-abortion care, Vitamin A, or female circumcision. The MTR team was asked to look carefully at these areas and recommend strategies and programmatic adjustments for USAID, where appropriate.

In HIV/AIDS, new directions have already been proposed. An HIV/AIDS strategy was completed in 1998 and will be implemented in 1999. The MTR was expected to consider the appropriateness of new activities within the overall program. Other activities such as social marketing and logistics management were felt to be essentially on track and so came under less scrutiny than other issues.

II. THE MID-TERM REVIEW PROCESS

A. PURPOSE

The specific purposes of the MTR were:

- To review and assess the investments and accomplishments of APHIA to date.
- To make recommendations about modifications, if any, which are warranted for the next six years of APHIA.
- To increase the awareness and local ownership of APHIA through sharing and requesting feedback on the hypotheses, findings, and recommendations of the MTR team through a series of focus groups and stakeholders' meetings.

The MTR team was not expected to propose changes to the overall strategic objective of SO#3 to *reduce fertility and the risk of HIV/AIDS transmission through sustainable integrated family planning and health services*. Nevertheless, the team was asked to propose as appropriate any recommendations or issues concerning the language, content, linkages, or direction of the intermediate results, sub-intermediate results, and activities.

B. ISSUES

The review team was asked to produce descriptive papers on many aspects of APHIA, although not all elements were reviewed at the same level of detail. The issues proposed for consideration in greater detail grew from a series of discussions held within the SO#3 core team about what needed to be better understood or clarified prior to continuing the implementation of APHIA. These elements included: reproductive health service delivery; training; IEC; child survival; and health sector reform. A number of cross-cutting issues were also identified to be considered within each issues paper: policy, adolescents,

gender, research, sustainability, project management options, quality improvements, regional focus. HIV/AIDS, governance, and poverty

In addition to the major focus issues outlined above, other key elements of APHIA were reviewed and presented in shorter papers. These included: logistics, social marketing, and the HIV/AIDS program. These issues were reviewed in with less emphasis because USAID felt that activities under these program areas are essentially on track.

C. METHODOLOGY

The APHIA mid-term review was a highly participatory process which entailed working through a large review team comprised of more than 25 members and consultations with nearly 300 partners and key stakeholders.

At the heart of the review team was a core group comprised of:

- a full-time team leader, hired under direct contract to USAID, whose responsibilities were to coordinate the review process, oversee the writing of issues papers, and produce the final report;
- five full-time independent consultants, hired under contract with a local consulting firm, whose responsibilities were to lead the technical teams tasked with investigation and analysis surrounding each of the five major issues and to draft the issues paper

A part-time independent consultant, hired under contract with the same firm, was responsible for facilitating three events: the two-day orientation and team building session, the team-synthesis meeting and the stakeholders' meeting

The extended review team included all staff from OPH, a staff member from the USAID/Kenya Controllers office, four REDSO/ESA staff members, three staff members from AID/Washington, a representative from the European Union, and the deputy head of the Division of Primary Health Care within the Ministry of Health. The extended team was constituted around the following groupings:

- The core team comprised of the team leader and the five independent consultants, each of whom was assigned to oversee the five major issues and who took the lead in guiding interviews, focus group sessions and field work;
- Core technical teams working on the major issues papers;
- Interdisciplinary field teams which were comprised of members from each of the core technical teams;
- Technical teams working on the other issues papers.

A considerable amount of the analytical work grew out of desk research and key informant interviews in Nairobi (see overview of MTR schedule in Annex B). These key informant interviews were conducted with officials from various divisions within the MOH, staff of cooperating agencies implementing activities with APHIA funding, and representatives from donor organizations.

Once the team members from REDSO and AID/W joined the review team, the core technical teams concentrated effort on synthesizing information and

impressions gathered up to that point. The teams also worked on developing protocols for fieldwork and the focus group discussions slated to take place at the end of that week.

Key informant interviewees figured heavily among participants in the focus group discussions, but an effort was made to broaden participation to include contributions from such quarters as academic staff of the University of Nairobi and the private sector.

In the interest of establishing some comparability across findings during the field trips, attention was paid to ensuring that the same types of contacts were made at each site to the extent this was possible. Field trips were originally envisioned to function mainly as a means to verify impressions obtained during desk research, key informant interviews and focus group discussions in Nairobi, but in fact they also brought out additional information and impressions.

The two-day team synthesis meeting did not achieve its purpose of synthesizing findings for the final report. Instead, core technical teams synthesized findings from field visits and developed consensus on key findings, conclusions and recommendations within each technical area. In addition to members of the extended review team, participants in this meeting included four staff members from other offices within USAID/Kenya. They were the Monitoring and Evaluation Officer, the Assistant Program Officer, the manager for activities under the Mission's Democracy and Governance Office and the Deputy Chief of USAID/Kenya's Agriculture, Business and Environment Office (ABEO). These participants received a briefing on MTR findings and also took part in a discussion of possible points of synergy among the various strategic objectives within the USAID/Kenya program. The outcome of these discussions will be reflected later in this report.

III. APHIA EXPECTED RESULTS AND ACCOMPLISHMENTS

A. INTRODUCTION

This section presents accomplishments to date under APHIA as evaluated against expected results. However, there are two sets of expected results: the current results framework and the expected results listed in the original APHIA design. The current results framework and expected results reflect changes in program emphasis which were necessitated by a funding cut, just as the APHIA design was being finalized. This cut resulted in truncating activities which had originally been planned, particularly in the areas of IEC, child survival and district focus. The discussion of accomplishments below centers primarily on expectations as presented in a document entitled "Performance Measurement Plan for 1996-2000." However, many of the original expectations for APHIA are still relevant to this discussion and will be touched upon.

B. THE STRATEGIC OBJECTIVE LEVEL

Results Framework

RESULT	INDICATOR	EXPECTED RESULTS
Reduce fertility and the risk of HIV/AIDS through sustainable, integrated family planning and health services	a. Total fertility rate b. Use of condoms with non-regular sexual partners (% of men 20-54 and women 15-49 using condoms with non-regular partners in the last six months	a. Total fertility at 4.0 by 2000 b. Condom use among women 15-49 from 16% to 23% by 2000 Condom use among men ages 20-54 increased from 30% to 44% by 2000

Accomplishments under APHIA

Total fertility rate TFR is estimated every five years as part of the Kenya Demographic and Health Survey (KDHS). USAID/Kenya reports annually on this indicator. Interim figures are derived from SPECTRUM projections based on CYP statistics. Kenya's total fertility rate has declined by 39 percent over fifteen years, one of the fastest fertility declines in the world. Results of the 1998 KDHS show continued and significant fertility decline. TFR estimates refer to the 3-year period prior to the survey, so the reported figure of 4.7 represents TFR for 1996. The APHIA program appears to be on track for achieving its target of 4.0 by 2000.

Use of condoms with non-regular sexual partners Data for this indicator is not comparable between the 1993 and 1998 KDHS because of differences in time frame posed. Respondents in the 1993 KDHS were asked about use of condoms with partners during the previous 6 months, while in the 1998 KDHS respondents were asked about behavior over the previous 12 months.

There is, however, useful information to aid in interpreting progress in reducing risk of HIV/AIDS transmission. Condom use as reported in the most recent KDHS is higher with regular and casual partners than with spouses. For men 42 percent of last sex with a regular partner and 43 percent with other partners involved use of a condom. For women the figures are 16 and 15 percent.

Many respondents indicated that they have changed behavior because of the HIV/AIDS epidemic. Among men, 90 percent responded that they have changed their behavior, the most commonly reported change being that they have restricted themselves to one partner (50 percent of respondents). Among the 77 percent of women who report that they have changed their behavior, restricting themselves to one partner is also the most frequently cited reason (47 percent).

Results of the 1998 KDHS show that knowledge about HIV/AIDS is nearly universal. Knowledge about condoms has also increased. Nearly 50 percent of male respondents know that condoms can be used to avoid AIDS, up from 36 percent in 1993.

C. INTERMEDIATE RESULT #1

Results Framework

OBJECTIVE	EXPECTED RESULT
1.0 – Non-USAID financial resources for FP, HIV/AIDS and CS increased	GOK multi-year plans for FP/HIV/AIDS/CS services developed Annual MOH cost-sharing revenue increased to US $10 million by 2000
1.1 – Collaboration with major European donors and Japan intensified	Selected donor expenditure for complementary FP/HIV/AIDS and CS activities increased
1.2 – Sources of funding for USAID FP service delivery programs diversified	Non-USAID financing for service delivery NGOs increased
1.3 – GOK contribution to immunization programs increased	Vaccine Independence Initiative established Percentage of vaccine costs paid by GOK increased

EXPECTATIONS UNDER ORGINAL APHIA DESIGN
MOH will have independent capacity to develop, monitor and update national implementation plans for FP and HIV/AIDS/STD prevention and use them to coordinate and budget local and external resources
A Vaccine Independence Initiative (VII) will have been launched to build self-reliance in the procurement of key public health commodities
Increased consistency among policies as expressed in the National Health Policy Framework, regulatory guidance and implementation on a national basis
Prototype planning and coordination structures will be established and functioning in selected districts

Accomplishments under APHIA

IR #1: Increased Non-USAID financial resources for FP/HIV/AIDS/CS

- A National Implementation Plan for family planning was developed and released in 1996.
- A *Sessional Paper on Population*, introduced to Parliament in 1997, is still not passed after being referred back for discussion to powerful, conservative groups who strenuously object to language referring to such ideas as reproductive health and condom promotion, especially as this relates to adolescents. At present, efforts to move passage of this paper forward are stalled.
- New guidelines on treatment of malaria were completed in 1998
- Kenya's AIDS Policy Environment score increased from 42.3 in 1995 to 57.5 in 1998. This improvement is related to a number of factors:

  USAID support to the GOK enabling it to better analyze and publish surveillance data on HIV from various rural and peri-urban sites.

USAID-supported training for planners and policy makers in both the public and private sector to increase awareness of impact of HIV and to anticipate and plan for the impact of AIDS in public sector budgets.

USAID partnership with the GOK in undertaking a number of studies to review policy implications of the epidemic. These resulted in a much acclaimed book, "AIDS in Kenya, Socioeconomic Impact and Policy Implications," in 1997 which is thought to have contributed to passing the "Sessional Paper on AIDS in Kenya" in 1997.

- To date US $32 million in cost-sharing revenues have been collected with revenues increasing from $8.5 million in FY 97 to $8.7 million in FY 98. According to GOK policy, 25 percent of all cost-sharing revenues are to be applied to primary care areas such as FP/HIV/AIDS/CS. Targets for this performance indicator have been exceeded. However, USAID noted in its recent R4 that cost-sharing revenues reported for FY 98 may be underestimated by as much as 50%, owing to the fact that controls over collections, reporting, and use of cost-sharing monies may have been weakened in recent years during the transition to decentralized management. In response USAID is assisting the GOK to strengthen fiscal controls. For example, installation of an automated collection system at Kenya's second largest hospital resulted in an immediate doubling of cost-sharing revenue. Current plans are to duplicate this system in other hospitals.

IR #1.1: Intensified collaboration with major European donors and Japan

- In the area of health reforms, USAID/Kenya collaborates with donors in two ways:

  First, through the Health Reform Donors working group comprised of DANIDA, DFID, EU, GTZ, SIDA, UNICEF, WHO and World Bank. The group meets regularly and has achieved several advances in the reform process. A statement of intent formalized in1998, spells out priority activities to be undertaken by the MOH in support of the reform process. USAID has been a key actor in mobilizing donor/MOH reform efforts.

  Second, with select donors in carrying out reform activities more directly tied to the APHIA project. APHIA is collaborating with JICA on rehabilitation of Coast Provincial General Hospital. While JICA funded the rehabilitation of the physical infrastructure, APHIA provides TA for strengthening hospital management and financial control systems. This collaboration is aimed at preparing the hospital to eventually assume semi-autonomous status from the government.

  DANIDA is the other major donor working in areas that directly impact MOH management. At present there is little systematic collaboration on the implementation level. This collaboration could be substantially improved. However, there may be little opportunity to do so in future, as there is strong indication that DANIDA may withdraw its support in the near future.

- USAID also collaborates with other donors in specific programs and activities.

Contraceptive commodities, once supplied almost exclusively by USAID, are today supplied almost exclusively by other donors.

The 1998 KDHS was co-funded by DFID and UNFPA

USAID was the lead donor in developing the AIDS/STD Working Group, which serves as a forum for discussion of technical issues related to HIV/AIDS.

DFID provides condoms to the social marketing program and also co-funded the Kenya Service Providers Assessment.

- The original goal under APHIA was to work collaboratively with other donors to leverage additional funding for service delivery programs. Present funding levels for USAID programs stand at about two-thirds of funding levels pre-APHIA. To a significant extent, increased funding from other donors has replaced rather than supplemented diminished USAID funding. In most cases future donor assistance to the public health sector will be static or decreasing.

IR #1.2: Diversified sources of funding for USAID service delivery programs

- USAID/Kenya has found it extremely difficult to track and report on this result. Discussions are now underway to consider dropping this from the results framework.

IR #1.3: Increased GOK contributions for immunization programs

- From USAID/APHIA funds, US$500,000 was deposited with UNICEF in 1996 towards purchase of vaccines for Kenya on condition that GOK include a line item for vaccines in its recurrent budget and sign a memorandum of understanding with UNICEF which commits an increasing amount for vaccines each year. Due to successful lobbying of GOK by USAID and other donors, GOK signed the Vaccine Independence Initiative in April 1999 which includes a line item for $60000 in the recurrent budget.

D. INTERMEDIATE RESULT #2

Results Framework for Intermediate Result #2

OBJECTIVE	EXPECTED RESULTS
2.0 – Capacity of public and private health institutions to finance, plan and manage resources increased	Per capita financing of health care increased Cost-sharing revenue as a proportion o f the annual MOH non-wage recurrent budget increased from 13.2% in 1994/95 to 25% in 2000
2.1 – Public sector financial resources for primary and preventive health-care increased	Percentage of revenue (including cost-sharing) retained at sub-district levels increased from 25% in 1994/95 to 50% Number of people covered through private health insurance and HMOs increased

2.2 – Organizational capacity and self-sufficiency of key private sector FP and HIV/AIDS service providers improved	Number of specified NGOs with cost-recovery mechanisms in place increased Percentage of recurrent costs recovered through cost-recovery increased Demand from NGO boards and management for assistance in strategic planning increased

EXPECTATIONS UNDER ORGINAL APHIA DESIGN
Cost-sharing revenue will increase to at least $9 million annually – from 25% to 50% of potential
The cost-sharing program will be implemented with increased efficiency
FPAK will achieve full programmatic sustainability and partial financial sustainability through fees for service and endowment fund
Chogoria will graduate from USAID financial support and achieve financial sustainability through a fee-for-service scheme and endowment
Christian Hospital Association of Kenya (CHAK) will institutionalize the independent capacity to manage sub-grants, expand and improve technical assistance (TA) and training to member organizations; 3 member organizations will achieve 70% financial self-sustainability
Private financing and management mechanisms will be expanded

Accomplishments under APHIA

IR #2: Increased capacity of public and private health institutions to finance, plan and manage resources

IR #2.1: Increased public sector financial resources for primary and preventive healthcare

- Impact of public sector activity is included under IR #1 with reporting of cost-sharing revenue. Other indicators for reporting on impact of interventions with the public sector – cost-sharing revenue as a proportion of the annual MOH non-wage recurrent budget and retention of revenue at sub-district levels – are in the process of being revised.
- APHIA's original expectation of increasing per capita financing of health care may have been misplaced as an indicator. In fact, Kenya's per capita health expenditures are high. At about $20 per annum, they exceed levels of any other country of comparable GNP. A recent National Health Accounts study suggests that the health financing problem in Kenya is less one of availability of resources than of the way the resources are used. For instance, it appears that people spend more on relatively low quality care in the form of over-the-counter drugs (about 29 percent of the total health bill), than the government spends (about 26 percent of the total bill) on health services.
- As a result of USAID assistance and support under APHIA, the GOK has successfully institutionalized the retention of cost-sharing revenues at district and sub-district levels. None of this revenue reverts to the central MOH or GOK Treasury. Cost-sharing revenues have provided a boost to primary and

preventive health care. The retained revenues support as much as 60-80 percent of annual non-wage recurrent expenditures. The down side is that these retained revenues have largely replaced rather than added to the central government funds made available to districts and sub-districts for primary and preventive health care services. Available central funds for health care have been further eroded with recent budget cuts for all ministries, including the MOH.

- The ultimate objective of the USAID-supported cost sharing program is to create a financing environment in the sector in which risk-share national and private health insurance will finance the bulk of curative care, thus freeing limited GOK resources to support primary and preventive health care services. This objective remains elusive due to reductions in GOK spending for health (related to the IMF structural adjustment program), and a general downturn in the Kenyan economy. The shortage of public financing is also exacerbated by fiscal mismanagement.

IR #2.2: Improved organizational capacity and self-sufficiency of key private sector service providers

- APHIA originally envisioned that a select few NGOs, who were traditionally supported by USAID and were also major private sector providers, might be candidates for transition to greater independence from USAID support, eventually leading to self-sufficiency. The APHIA Financing and Sustainability (AFS) Project started with four major NGO candidates: CHAK, Mkomani Clinic Society, Chogoria and FPAK. The first two were eliminated for assistance early on because of transitional management problems. A second round of candidate organizations (3-6) are now under consideration.
- *Chogoria* This is a Presbyterian Church facility which includes a 300 bed hospital, 30 outreach clinics and a large community-based health program in a catchment area of 450,000 people. Assistance under the AFS project has helped the facility to identify inefficiencies and develop strategies to reduce financial losses and ultimately reduce its dependence on external donor assistance. The result so far is that the facility has divested itself of operations which run at a loss. It is also piloting employee incentive schemes to improve clinical services and customer service in the hope of enticing back clients who had defected to newly established private clinics.
- *Family Planning Association of Kenya (FPAK)* A striking observation on visits to FPAK facilities during field trips is the lack of clients in FPAK facilities compared to other clinics. This is generally attributed to the fact that FPAK is known to the public as a provider of family planning services despite the fact that FPAK has instituted a broader array of family health and preventive services such as safe motherhood, STD counseling and testing. Under the AFS project, APHIA has been working with FPAK on reinventing its image as a provider of family health services and making the public more aware of the range of health services available at FPAK clinics. This assistance is in its early stages; it is not possible at this point to assess impact.

E. INTERMEDIATE RESULT #3

Results Framework for Intermediate Result #3

OBJECTIVE	EXPECTED RESULTS
3.0 – Increased customer use of integrated FP/HIV/AIDS/CS services	Contraceptive prevalence rate for modern methods increased among all women from 21% in 1993 to 38% by 2000 Trust condom sales increased from 2 million in 1994 to 3.5 million in 2000 National CYPs rise from 1.4 million in 1994 to 2.4 million by 2000
3.1 – Policies and program approaches for FP, HIV/AIDS and CS services improved through research, analysis, monitoring and evaluation	Number of annual AIM presentations increased Family planning projections updated and disseminated The KDHS completed and disseminated by 1999 A functional OPH M&E system developed
3.2 – Prevention and management of childhood illnesses including malaria improved in a target district	Improved management of fever and anemia, principally among children under five, by health workers at the health facility Improved capability of mothers and other caretakers to manage fever and anemia at the household level Improved prevention and management of malaria in pregnancy Increased household use of insecticide treated materials Effective collections and use of information for planning, monitoring and evaluation.
3.3 – Key FP and HIV/AIDS service delivery support systems strengthened and institutionalized	Proportion of SDPs maintaining an adequate supply of low-dose pills and condoms increased – target is 90% adequacy at 80% of SDPs Targets are met for annual no. of FP service providers receiving refresher training National FP logo adopted and launched
3.4 – Integrated FP and HIV/AIDs services provided by selected NGOs and CAs	Number of sub-locations receiving CBD services increased from 3700 in 1995 Increased number of VSC sites Service delivery sites providing integrated FP/HIV/AIDS services CYP in USAID-funded programs increased from 400,000 in 1994 to 850,000 by 2000 Increased proportion of contraceptive users in USAID-funded programs using long-term methods

OBJECTIVE	EXPECTED RESULTS
3.5 – Increased availability of effective, gender sensitive, HIV/AIDS responses in selected populations	Strengthened capacity of key stakeholders to build an enabling environment for HIV/AIDS/STI prevention and care activities Improved capacity of selected communities to identify their needs and develop, coordinate and implement appropriate HIV/AIDS/STI prevention and care activities Improved capacity of public and private institutions to increase demand for and delivery quality HIV/AIDS/STI prevention and care services

EXPECTATIONS UNDER ORGINAL APHIA DESIGN

Research, Evaluation and Monitoring

Priority research will be completed and results used to inform policy and improve access to and quality, cost-effectiveness and sustainability of services

A KDHS III will be implemented and results utilized to improve program effectiveness and impact

A national HIV surveillance system will be functioning and informing program planning

Program Planning & Coordination

Selected organizations – National Council on Population and Development (NCPD),National AIDS Control Programme (NACPS), University of Nairobi (UoN), selected district health management boards (DHMBs) will have capacity to utilize forecasting and projection tools & techniques for updating and modifying implementation plans and allocating resources

MOH will have independent capacity to develop, monitor and update a national implementation plan for FP and HIV/AIDS prevention and use these for estimating, coordinating local and external resources

Integrated Management of Childhood Illness

There will be systematic use of WHO and UNICEF algorithms designed to ensure appropriate immunizations and improve recognition and treatment of major childhood illnesses at first-level health facilities

Field tests of impregnated bed nets and other interventions in malaria prevention and case management will have been undertaken

Health workers will receive improved supervisory support to provide higher quality services

RH Services

Total CYPs will increase from 400,000 to 850,000 representing growth from 32% to 38% of services provided nationally

Services will broaden to include STDs, particularly HIV. Between 60 and 70 private hospitals and health centers will provide screening and appropriate treatment for STDs, 4000 community outreach workers will be able to correctly counsel and refer clients for FP and STD treatment

The Population Services International (PSI) national condom social marketing program will have increased sales from 6 to 10 million annually (8% of condoms distributed nationally); will have made the transition to a Kenyan NGO or company (or will have been incorporated into an existing Kenyan organization); will posses the independent capacity to manage a national social marketing program; and will have made significant progress towards financial independence

FP services will be focused on permanent and long-term methods where appropriate and on improved targeting to adolescents and men

FP staff at all levels will have enhanced capacity to provide integrated RH services

Health personnel will have strengthened capacity to deliver maternal health services and to recognize high risk pregnancies, high risk labor and delivery and the need for referral

Service delivery capacity and sustainability for selected NGOs will improve

Quality Assurance and Supervision
MOH will have defined and implemented a national supervisory structure for all levels of service delivery

Strengthened methods of supervision will be widely implemented at both public and private service sites

A 1999-2000 Situation Analysis will show measurable improvements in quality of public and private RH services

Training
Pre-service institutions will have added integrated RH training to their curricula

Division of Nursing (DoN) Division of Family Health (DFH) and Dept. of OB/GYN (University of Nairobi) will be coordinating activities related to in-service training of doctors, nurses and clinical officers in integrated FP/RH

A network of rural health training centers (RHTCs) will replace the 12 decentralized training centers (DTCs). These RHTCs will have developed and implemented cost recovery plans for financial self-sufficiency targeted to attract and service priority markets for training accommodations

The DFH and DoN will have jointly established a formal structure and regular activities for district and sub-district level supervision of integrated FP/RH services

National training programs which focus on family planning will be institutionalized and integrate HIV/AIDS/STD and other aspects of reproductive health

Provincial level supervisory and quality of care oversight will be incorporated into a decentralized management approach

Logistics
The Reproductive Health Logistics Unit (RHLU) will be fully integrated into the MOH logistics system

The national FP logistics program will have incorporated commodities related to HIV/AIDS/STD prevention, notably drugs

All SDPs will routinely maintain 90% of commodities requirements

All private sector providers will be fully integrated into the national RH logistics system

A Contraceptive Independence Initiative (CII) will have been launched to build self-reliance in the procurement of key public health commodities

The JSI Private Sector Family Planning Project will have made the transition to a Kenyan NGO or company with the independent capacity to plan strategically; solicit, raise and account for funds; provide TA and training; and develop, monitor and evaluate sub-grants to the private sector to establish, expand and improve health services

IEC
The national population and FP IEC program will be broadened and institutionalized to include selected messages related to HIV/AIDS/STD and maternal, reproductive and child health;

MOH will have independent capacity to develop and revise periodically a coherent, integrated national IEC strategy and implementation plan and will function successfully as a national IEC program coordinator

HIV/AIDS/STD prevention and selected messages regarding maternal, reproductive, and child health will be integrated into population and family planning IEC plans and programs

IEC will be targeted more effectively to the most vulnerable and needy – those at risk of STD/HIV infection those with unmet need for family planning and adolescents

A private Kenyan organization(s) will have capacity to provide technical expertise in design, testing, production and evaluation of IEC programs

MOH will have independent capacity to contract IEC materials production to the private sector

District Focus

Reduced geographic differences in use of health and FP services and in health and fertility status

Requirements necessary to achieve measurable impact on HIV transmission attributable to the project will have been documented and disseminated

HIV sentinel surveillance sites will report data regularly and accurately

Efficacy of behaviour change communications with targeted groups will have been fully documented

DHMTs and DHMBs will have assumed primary responsibility for a wide range of cost-sharing related activities, using a district management approach suitable for replication throughout Kenya

DHMTs and DHMBs will control and use cost-sharing funds appropriately

DHMT and DHMB management capacities will be improved in areas such as quality assurance, personnel management, planning, budgeting

Community initiated pharmacies will have improved capacity to effectively use the revenue generated from fee collection and communities will have improved capacity to undertake social marketing & other income-generating projects

The technical, resource, management and coordination requirements necessary to reduce the risk of HIV/AIDS transmission at the district or sub-district level will have been documented and disseminated

DHMTs and DHMBs will have assumed primary responsibility for many essential cost-sharing management functions

Accomplishments under APHIA

IR #3: Increased customer use of integrated FP/HIV/AIDS/CS services

- *Contraceptive Prevalance* The contraceptive prevalence rate for modern methods among all women according to the 1998 KDHS was 23.6 percent which falls far short of the 32.8 percent target. Between 1984 and 1993, nearly 2 percentage points were added to the contraceptive prevalence rate for modern methods each year. This has slowed to less than one percentage point between 1993 and 1998. Given this slower rate of uptake, it is not likely that the goal of 38% contraceptive prevalence for modern methods among all women will be met by 2000.
- *Average monthly condom sales* This indicator tracks the number of condoms sold through the successful Trust social marketing program managed under a cooperative agreement with PSI. The actual figure for 1998 is 838,000 as reported in the 1999 R4 (FY 2001). Thus the target for 1998 of 768,000 was easily exceeded. Targets were revised downward in 1998 to reflect a more realistic annual growth rate of 40 percent. However, recent research comparing international social marketing programs indicates that the targets may have to be revised further downward. Average annual sales growth for mature projects is approximately 15 percent. [1]

[1] See Issues paper on Social Marketing.

- *National CYPs* This service statistic, compiled by FPLM, reflects commodities distributed throughout the national system. During interim years between KDHS, this figure helps assess progress toward achieving targets for CPR and TFR. The recent completion of a database of all health facilities in the country now ensures a greater degree of accuracy in estimating this figure. As per the recent R4 (FY 2001), progress in achieving targets is ahead of schedule with a reported figure of 2.0 million against a target of 1.9 million.

IR #3.1: Policies and program approaches for FP, HIV/AIDS and CS services improved through research, analysis, monitoring and evaluation

Activities under this intermediate result include a host of research projects through various cooperating agencies

- *Macro International* is the primary contractor working on the KDHS conducted every five years. This survey is the central source of information on fertility patterns, contraceptive use, and status maternal and child health. KDHS results are widely used in strategic planning and analysis by USAID, its cooperating agencies, the MOH and donors. The results of the 1998 KDHS will be officially presented in May 1999.
- *Family Health International* conducts research on issues related to the efficient and effective provision of family planning services under conditions of epidemic levels of HIV. The research agenda for FHI is on track and has informed many aspects of investigation and analysis for the APHIA review.
- *The Population Council* conducts most of its relevant research through two projects:

  FRONTIERS, the goal of which is to improve service delivery through operations research

  HORIZONS, the goal of which is to identify "best practices for prevention of HIV and other STIs and to mitigate the impact of HIV/AIDs through operations research."

  All activities in the Population Council workplan are on track.
- *The POLICY project*, with the Futures Group as the primary contractor, is a key USAID-funded effort to assist the GOK in identifying and overcoming policy constraints which limit or slow expansion of programs in family planning and HIV/AIDS. Initiatives under the policy project include the following:

  working closely with the GOK through the National Council for Population and Development (NCPD) to prepare family planning analyses and projections based on KDHS results which are in turn used for policy analysis, advocacy and planning;

  working through the Kenya AIDS NGOs Consortium (KANCO) network on an initiative to support RH advocacy for youth;

  working in the area of HIV/AIDS to conduct workshops to sensitize key policymakers and other leaders, to support leadership in setting priorities for HIV/AIDS research and to foster leadership at district level

in AIDS prevention (this follows on previous work undertaken by FHI through late 1998); and

providing technical assistance to NASCOP with its mandate to strengthen DIACs, review the HIV sentinel surveillance system and data, use the Spectrum software to model HIV/AIDS projections for Kenya.

All activities under POLICY are on track. The current workplan will end in August 2000.

The indicators not discussed above under this sub-intermediate result is the establishment of an OPH monitoring and evaluation system. The APHIA performance measurement plan for 1996-2000 is a work in progress with baselines and targets to be determined for many indicators, including those under IR 3.1. Suggestions to be considered in amending the current plan will be presented among the recommendations.

IR #3.2: Prevention and management of childhood illnesses including malaria improved in a target district

The Bungoma District Initiative (BDI), now renamed the Bungoma District Malaria Initiative by the DHMT, has successfully influenced district and provincial authorities to adopt and disseminate malaria guidelines developed on the basis of research conducted jointly by CDC and KEMRI. However, relations between the researchers and local authorities at both district and provincial level appear to be problematic.

BDI is successfully meeting objectives of improved management of childhood illness and malaria at the facility level. Evidence gathered during field trips show health workers are adequately diagnosing and treating fever and anemia. Two of three facilities visited showed adequate stocks of Sulfadoxine/Pyrimethamine (SP) and iron folate; and health workers were prescribing SP as first line treatment for malaria

It is too early in project implementation to assess progress at the household level, since the project was launched in March 1998.

IR #3.3: Key FP and HIV/AIDS service delivery support systems strengthened and institutionalized

- *Logistics* The JSI/FPLM project in conjunction with the Logistics Management Unit (LMU) under the Division of Primary Health Care has been highly successful in improving the logistics management system and extending its scope to handling other commodities without compromising efficiency. Accomplishments include the following:

  Stockout rates for contraceptive products throughout the system have remained consistently below 20 percent since 1995. 90 percent of all stores have a three-month supply of contraceptives and STI antibiotics.

  Upon request from DFID in 1995 to handle STI commodities (drug kits and test reagents), LMU successfully integrated these commodities into the system. The system easily expanded to include 500 service delivery points within the DFID program, 337 more facilities than had been planned.

Commodities management is widely considered to be a major comparative advantage of USAID programs by other donors, and the logistics management program in Kenya serves as a model for other countries in the region.

FPLM is now in the process of working with the Medical Supplies Coordinating Unit in its effort to restructure as a parastatal organization which would procure and distribute all drugs and supplies to outlets around the country. The new system would be based on the current logistics management system.

- *Training* Most of the activities evaluated under the training component of APHIA have been undertaken through add-ons and field support transfers to JHPIEGO. Training efforts have been concentrated on pre-service and in-service training for nurses. Actual training was one of the activities affected by the budget cuts, thus accomplishments reflect mainly achievements in working at the national level to bring about improvements in the training system. Accomplishments are as follows:

  A decentralized reproductive health training system has been established (including 12 decentralized training teams and 74 model sites equipped to provide clinical training), and the Division of Primary Health Care has evolved from being primarily a training body to one that sets clinical and programmatic standards and is responsible for monitoring quality of training. This effort included the development of a training information monitoring system which helps ensure that trainees are appropriately selected.

  RH is now part of the pre-service curriculum in medical training institutions. A wide range of curricula and supporting materials have been developed and national service delivery guidelines now reflect WHO standards. These new national guidelines have been published and disseminated to key administrators, educators and service providers but have yet to be distributed to all service delivery points. JHPIEGO has also worked with the DPHC and other organizations to produce a country training strategy for Kenya, which when fully implemented will help to ensure appropriate training and deployment of health personnel.

  Innovative and effective training approaches have been developed in response to the demonstrated need for skills-oriented, more practical approaches. These include methodologies for on-the-job training which help ensure that trainees have ample opportunity to practice clinical skills under closer supervision. There is some evidence to show that on-the-job training is likelier to benefit younger practitioners with longer years of service in front of them. These practitioners, who are often women with young families, find it difficult to participate in a six-week residential course. Experience to date has been that participants in such courses are most likely to be older practitioners who are nearing retirement from public service and wish to acquire credentials for establishing private practices.

A preceptorship system for supervising trainees has been institutionalized. These preceptors are service providers whose duties include clinical training and supervision of their peers. The advantage to this facility-based system is that trainees are more closely supervised as they acquire necessary clinical skills; and more service providers can be trained.

Due to financial constraints, the MOH was not able to rehabilitate the network of seven RHTCs to replace the DTCs currently operated by DPHC, nor have recovery plans for financial self-sufficiency been developed.

AVSC activities in connection with training in long-term methods: implants, tubal ligation and vasectomy – have also entailed introduction of new training methodologies, quality approaches and tools. AVSC works in both government and private facilities. In private facilities (FPAK, MSK, CHAK and Pathfinder grantees) facilitative supervision, quality improvement approaches and tools have been introduced. In government facilities where regional supervisors from the MOH are responsible for introducing and implementing quality improvement approaches, the supervisors have introduced these tools in facilities where they are based but not in other institutions in their regions. Quality improvement approaches are at different stages among provinces.

- *IEC* Under the original APHIA design, IEC activities were intended to be broader in scope, as evidenced by the level of expected accomplishments listed in the table above. JHU/PCS was tasked primarily with the responsibility of working at the national level to foster institutional capacity within the MOH to provide national IEC leadership. The IEC program was scaled back due to funding cuts. What remained in the JHU workplan included work on the FP logo and technical assistance to the Division of Health Education, now renamed the Division of Strategic Health Communication (DSHC), as it formulated a national IEC strategy. Results can be summarized as follows:

  JHU worked with the MOH to recast the original family planning logo as a family health logo in response to increasing emphasis within the MOH on integrated preventive health care. The new logo, launched in March 1999, integrates the various components of an RH program including family planning, safe motherhood, child immunization, and STD prevention, treatment and counseling (including HIV/AIDS).

  The DSHC has developed its national health communication strategy and the launch is set for June 1999. This achievement is, however, mitigated by the fact that the DSHC has yet to credibly establish itself as a leader in health communication among government agencies. This health communication strategy is one of three currently in existence, the other two have been developed by the National AIDS Control Programme and by the National Council on Population and Development.

Technical assistance in IEC has also been provided by FHI under APHIA and has contributed to capacity building among other agencies such as PATH,

Pathfinder, MAP International and KANCO, all of which have acknowledge the role played by FHI in creating linkages between the GOK and the private sector in providing IEC services.

IR #3.4: Integrated FP and HIV/AIDs services provided by selected NGOs and CAs

- *CBD/Clinical Programmes and CYPs* USAID supports several organizations which field a total of 1983 CBD agents and 1200 community volunteers. Direct grantees include: Pathfinder, FPAK, Marie Stopes Kenya. Four Kenyan NGOs – Mkomani Clinic Society, Anglican Church of Kenya, Kabiro Kawangware and Maendeleo ya Wanawake Organisation (MYWO) – are supported as sub-grantees to Pathfinder. All CBDs are trained in providing information, counseling and referrals for STIs and HIV/AIDS. Both Marie Stopes and Pathfinder have recently included services in home-based care. All programs include both CBD and clinic-based services.

  Over the past four years FPAK and Pathfinder programs have not met planned actual CYP targets. (The Marie Stopes Kenya grant with USAID began in August 1998, and it is too early to evaluate their activities).

  At FPAK, CYPs provided through both CBD and clinic services have declined drastically since 1995. The decline in CBD performance is attributed to the effects of APHIA budget cuts. FPAK cut back its CBD program, reducing both the number of CBD agents and supervisors. The reasons for decline in CYPs generated through clinic based services is less clear. One explanation is that FPAK has the reputation of being a family planning service provider and the fact that it is now offering a wider array of services is not well known within its catchment areas. With assistance under the AFS project, FPAK is now in the process of developing a marketing strategy to position itself within the private sector as a provider of more comprehensive health services.

  Pathfinder grantees have also registered a decline in CYPs generated through CBD programs, although to a lesser degree than FPAK. This decline has been attributed to introduction of fee-for-service and retrenchment of CBD services. Retrenchment in the case of Pathfinder entailed no cutbacks in supervision. Instead the number of CBD agents receiving allowances was reduced and training activities were frozen. After dropping off in 1995, the number of new acceptors of FP services began to rise in 1996 and gained momentum last year when new acceptors rose by 33%. Pathfinder supported clinics registered an increase of 5% of new acceptors over the same period. This could be evidence that CYPs will begin to turn around now that clients have begun to accept the fee-for-service system.

- *Sites offering permanent and long-term methods*

  Under its grant AVSC has provided assistance and training to equip 80 facilities to provide permanent and long-term methods. These facilities include 52 public hospitals, 11 FPAK clinics and 17 CHAK clinics. Since 1995, however, the number of procedures reported by AVSC sites has been declining.. Reasons for the decline in cases reported from AVSC sites are not well understood. The KDHS shows increasing demand for these

services. With just about half of all AVSC sites reporting regularly, there is a likelihood that figures have been underreported. A recently conducted AVSC internal evaluation noted that with decentralization of management responsibilities to local authorities, there had been a lack of clarity in establishing reporting responsibilities for regional supervisors. The decline in reported figures could also be partly due to the consequences of a strike by the doctors in 1997 and the nurses strike in late 1997/early 1998. While recent KDHS figures show an increase in percentage of married women using longer-term and permanent methods of contraception compared to the 1993 KDHS , these women are not asked when procedures were performed.

- *Integration of services* The Integration Working Group, which functioned for three years beginning in 1994 with funding to Pathfinder, played a valuable role in clarifying issues related to integration of FP/HIV/AIDS services. FHI, under the AIDSCAP project that ended in 1997, developed a curriculum for training in HIV/AIDS counselling. However, integration of STI/HIV/AIDS services in family planning clinics is limited. Many service providers, though trained, have not really internalized the fundamental skills and attitudes needed to function as effective advocates for informed choices and behavior change. Many have reservations about discussing sexual behavior with clients – particularly with adolescents

- *Targeting of services* There are programs under APHIA which are designed to target special groups – men and adolescents. These include the following:

  Kenyatta National Hospital: The High Risk Clinic has as its main objective to improve RH of young, unmarried women. Among other services this facility provides post-abortion emergency care. More than half its clients according to a 1997 evaluation accept family planning methods. Its records show high revisitation of clients.

  Pathfinder: Peer counseling programs at Egerton and Kenyatta universities; opening of clinics to men only on Saturdays and Sundays. Staffing clinics with more male service providers. Pathfinder along with other CAs has recently been awarded a cooperative agreement as part of an initiative in community-based HIV/AIDS prevention and care which specifically targets youth along with persons living with AIDS and their families.

  FPAK: Two youth centers; three men only clinics (established with IPPF support).

  PSI: The social marketing program for condoms targets youth between ages 15-24.

  Despite efforts to target special groups with RH services, APHIA has in general failed to connect with adolescents and men. There is evidence in the service delivery analysis of widespread failure to contact adolescents through CBD programs, particularly with HIV education and counseling. Most CBD agents are older women who cannot relate comfortably to men and

who generally do not think it is right to provide contraceptives to unmarried girls who are not married or have not yet been pregnant[2]

IR #3.5: Increased availability of effective, gender sensitive, HIV/AIDS responses in selected populations

USAID played a leading role at the national level by influencing policy development and by supporting donor coordination and dialogue. (Achievements are noted above under IR #1). USAID also pursued other strategies for achieving results under IR #3.5.

- Increased access to condoms and improved management of STDs The USAID-funded social marketing program was intended to work in three settings: the national level, in USAID-funded non-governmental integrated service delivery settings, and in selected focus districts. The district focus dropped out with cuts in APHIA funding, however social marketing efforts undertaken by PSI at the national level and in non-governmental service delivery have been highly successful with sales of Trust condoms consistently exceeding expectations. The original APHIA design had anticipated more progress in program sustainability than has been achieved. Condom sales in private sector settings were expected to move progressively from "free to fee". Although this has not happened to the extent envisioned, there is encouraging recent survey data showing that a significant number of people are willing to pay for condoms. APHIA had also originally expected that a sustainable mechanism would be in place by the end of 2001 to enable private sector sales of condoms to be continued without additional donor funding. The development of a private sector entity is only just now becoming a reality. This year PSI plans to complete the registration process to form a local entity, the Social Marketing Initiative of Kenya, and to continue to transfer managerial capacity to local staff.
- Integration of HIV/AIDS/STD services into the FP/MCH service delivery network USAID has promoted this through information sharing, training and research. As discussed above under IR #3.4, a great deal remains to be done in integrating services.
- Implementation of a comprehensive set of activities in a defined geographic area The district focus, as originally planned, was intended to work in several districts where needs were greatest for strengthened health, FP and RH services. HIV/AIDS activities were to be a cornerstone of the work to be undertaken in these districts. This comprehensive focus was dropped in the wake of APHIA funding cuts. As a result of a funding windfall from the AID/W program, the Africa Integrated Malaria Initiative (AIMI), the district focus was transformed into the Bungoma District Initiative which focused on malaria in children and pregnant women. Achievements are discussed above under IR #3.2
- Communications focused on behavior change and including behavioral research to develop appropriately targeted messages FHI has undertaken

[2] A 1997 Population Council study found that only 26 percent of CBDs would provide contraceptives to an unmarried girl who has not yet had a child or become pregnant. Observations by the MTR team in the field support the conclusion that provider attitudes have basically not changed since this study.

many behavior change communications under APHIA, first under its AIDSCAP project, which ended September 1997, then through a cooperative agreement which ended in FY 1999 and now under a field support transfer to the IMPACT project. FHI activities comprise interventions in behavior change communication, policy, STD training, capacity building, surveillance and research. Evaluations of over 20 subprojects have showed impressive results through interventions which include mass media, theater troupes, peer education programs in universities and worksites and support to NGOs to develop IEC materials. HIV/AIDS work was also undertaken by other cooperating agencies such as PSI), Johns Hopkins PCS, Pathfinder, FPAK and PATH.

In May 1998, USAID reviewed its approach and developed a new HIV/AIDS strategy, which was designed to keep the most successful elements of the previous program and add new elements. Dimensions of this new strategy include the following:

Continued emphasis on prevention of sexual transmission with strategies designed to reach people through a variety of settings – places of work, clinics, other places where people congregate – with messages about condom promotion and management of STIs. This emphasis included taking a new and focused look at behavior change interventions. Emphasis is placed on targeting youth for HIV/AIDS services.

Continued support to social marketing of condoms

Continued support for policy and advocacy interventions with key persons and groups in both the public and private sectors

Support for expansion of voluntary counseling and testing services in selected sites

Support to the MOH in development and dissemination of a national blood policy in the interest of improving blood safety

Support to the MOH in strengthening serological and behavioral surveillance; conducting and disseminating results of behavioral surveillance surveys

Support for research on topics related to (a) prevention and control of HIV/AIDs and other STIs; (b) mother to child transmission of HIV and (c) expanding the FP method mix to include a larger array of barrier methods in general and female-controlled methods in particular

Support for community-based prevention and care of AIDS affected persons. (Pathfinder was awarded a cooperative agreement in May 1999 to undertake programs in this area.)

IV. SUMMARY: ACCOMPLISHMENTS AND GAPS IN ACHIEVING EXPECTED RESULTS

A. SUMMARY OF ACCOMPLISHMENTS UNDER APHIA

- ***Family Planning:*** Between 1983 and 1998, modern contraceptive prevalence (among married women) has nearly doubled from 18 to 31 percent, among the most rapid, sustained increases in the world. Among African countries, only South Africa and Zimbabwe have higher prevalence. Due principally to this increase in prevalence, the total fertility rate has fallen dramatically over the past 20 years, from an estimated 8.1 to 4.7 children per woman between 1976 and 1996. This 40 percent decline in fertility eases the pressures of population growth on Kenya's society, economy and environment; however population growth is still a concern with growth rates estimated at 2.0 to 2.5 percent. Over half of Kenyan women using modern contraception seek family planning to space their births. The combination of limiting (reducing 4th and higher-order births and births to mothers age 35 and higher) and spacing births (delaying first birth to age 18 and spacing 24 months between births) has an important impact on child survival (CS). Births in these high-risk categories in Kenya carry a 65 percent higher risk of infant mortality.

- ***HIV/AIDS:*** While the epidemic is expanding, there are signs that sexual and reproductive attitudes and behavior are changing. Nearly all reproductive age women and men have heard of AIDS and roughly 85 percent know at least one way of avoiding infection. Nearly 40 percent know at least two of the four important ways of avoiding infection. Among men, nearly 50 percent know that condoms can be used to avoid AIDS, up from 36 percent in 1993. And 90 percent report that they have changed their behavior in some manner to avoid AIDS, with 50 percent limiting sex to one partner, 20 percent using a condom, and 15 percent abstaining from sex. Among women, 77 percent report that they have changed their behavior, with 47 percent limiting sex to one partner, 3 percent using a condom, and 19 percent abstaining from sex. In areas of high HIV prevalence, such as Nyanza, these behavior change percentages are generally higher.

- ***Health Care Financing:*** There have been marked increases in revenues generated through cost-sharing activities, growing from under $US 1million in 1990 to $4 million in 1993 to over $8 million in 1998. This initiative has been critical to increasing the sustainability and improving the quality of public health services. It has also been a cornerstone of national health reform as it has worked to devolve authority and accountability in public health to the district level. This initiative has also lent support to the privatization of two major hospitals and the sustainability of health NGOs through shared-risk insurance.

These gains are particularly commendable given that the APHIA program has been operating at funding levels reduced by one-third. But continued progress

in these areas is by no means assured and continued investments by USAID is key to future progress in this important sector.

B. SUMMARY OF GAPS IN ACHIEVING EXPECTED RESULTS

- **Contraceptive prevalence:** The contraceptive prevalence rate for modern methods according to the 1998 KDHS, 23.6 percent among all women, falls far short of the target of 32.8 percent. The rate of uptake has slowed, thus making it unlikely that the goal of 38% contraceptive prevalence by 2000 will be met.
- ***CYP targets for USAID-funded programs:*** CYP fell far short of expected targets for USAID funded programs through Pathfinder (and its grantees), AVSC, and FPAK. Reasons for this appeared to be closely tied to programmatic decisions taken in light of budget cuts in the case of Pathfinder and FPAK which resulted mostly in drastic changes within the CBD programs, i.e. cutbacks in training, numbers of supervisors, numbers of CBD agents. The reasons for decline in CYPs in the AVSC program are less clear and require further investigation.
- ***Unmet needs among specific target groups:*** The review team noted that the most striking gaps in services and IEC support are for youth (all services), men (information about family planning), families affected by HIV and services for other vulnerable groups, e.g. AIDS orphans and children under adolescent age in general.
- ***Integration of CS/HIV/AIDS/FP services:*** USAID has promoted integration of services in traditional MCH/FP service sites through information sharing, training and research. Findings from the mid-term review, however, show that integration of services has not taken hold to the extent envisioned in the APHIA design. This is reflected in the fact that documentation does not present a consistent definition of reproductive health. In the field, the integration of STI/HIV/AIDS in family planning clinics is limited. Many service providers have not been adequately prepared to provide STI services and have reservations about discussing sexual behavior with clients. Research projects funded under APHIA tend to be oriented toward family planning or STI/HIV/AIDS, though this is changing. There appears to be a need for more regular consultation among various divisions within the MOH, particularly between DPHC and NASCOP, as well as among various CAs handling different programs. As one key informant noted “the family planning people and STD people don’t seem to talk to each other very much.” As for the integration of child survival, the main thrust of integrating child survival was tied into the district focus component of the original design. This was lost when APHIA funds were cut and the decision was taken to drop this component. USAID had at one point providing funding for an integration working group among the CAs which functioned from 1994-1997.

V. ISSUES, CONSTRAINTS AND RECOMMENDATIONS

A. ISSUES

There are urgent issues which make continued investments by USAID necessary to assure continued sustainable reduction in fertility and risk of HIV/AIDS transmission:

- **Increased cohorts entering their reproductive ages*:*** Since 1980, the number of women in their reproductive ages has more than doubled from 3.4 to 7.2 million. Because the cohorts now entering their reproductive ages today were born 15-20 years ago when fertility in Kenya was at its peak level, the size of the reproductive age population will continue to grow markedly in the years ahead. Over the next 5 years, the number of women of reproductive age will grow by more than 1 million to 8.3 million. This means that the number of contraceptive users will need to grow by 3 percent each year just to maintain current CPR. For modern CPR (among all women) to increase from 24 percent today to at least 38 percent[3] over the next five years, the number of users must grow from 1.8 to at least 3.1 million – a 75 percent increase. These increased cohorts also translate to greater numbers each year potentially exposed to the risks of HIV infection – such that activities aimed at AIDS prevention must expand 3 percent annually just to keep pace with this growth, let alone expand coverage. Likewise, this dynamic also works to offset fertility declines, such that number of births each year may well increase even with continued declines in fertility.

- **Unmet need for family planning*:*** Despite the remarkable growth in family planning use in Kenya, 24 percent of currently married women express an unmet need for family planning – wishing to limit or space their next birth but remaining exposed to pregnancy. Contraceptive prevalence (all methods) would rise to over 60 percent if this unmet need were satisfied. Similar high rates of prevalence would be realized if women reporting that they intend to use family planning in the next 12 months were to follow through on that intention. Using either measure, there is a clear need for continued expansion of access to quality family planning services. Of total demand for family planning, over half is for limiting births which should translate to longer term methods. Based on intended future method, there is a strong reported preference for injectibles and to a lesser degree pills.

- **Expanding HIV/AIDS epidemic*:*** HIV/AIDS prevalence among adults has increased from 5 percent in 1993 to 9 percent in 1997. In all sentinel sites in Kenya, the rate of HIV prevalence continues to increase, indeed there is every evidence that other communities are rapidly catching up to levels of infection common in western Kenya. Some 28 percent of pregnant women in Nakuru (Rift Valley Province) tested HIV-positive in sentinel surveillance in early 1999. In NyerI (Central Province) prevalence rates have doubled from 9 to 18 percent in a single year; and in Meru they have almost doubled from 13 to 25 percent in the same time frame. There is speculation that

[3] The target CPR for the year 2000 is 38 percent.

prevalence may have stabilized in Kisumu, where HIV prevalence rates were for a long period higher than elsewhere in Kenya, but at a level above 30 percent.

HIV infection is most common among young adults, with 70 percent of all infections concentrated in ages 18-25. Girls and young women, where rates of infection are increasing at higher rates than among males, are at greatest risk. It is well established epidemiologically that younger women are especially prone to vaginal trauma than facilitates HIV transmission. Recent data from Kisumu suggest that an alarmingly high proportion of girls are becoming infected at or very close to the start of their sexual lives. Some 18 percent of girls in a household survey were infected with HIV within a year of losing their virginity

Young adults are a particularly difficult group to reach. Most health systems are oriented toward adult clients, and there is considerable resistance in some quarters to providing condoms and contraceptives to youth. Because of population momentum, and the youthfulness of Kenya's age structure, growing numbers each year enter reproductive age and are exposed to the risk of infection. Because the illness caused by the virus strikes people in their most productive years, the epidemic threatens the stability and prosperity of Kenyan society. It will also place a serious strain on health care systems. It is estimated that by the year 2000, half of the hospital beds will be filled by AIDS patients.

The expanding HIV epidemic is also having a severe effect on one of the most vulnerable groups in Kenya – its children. Increasing numbers of children are both infected and affected by HIV/AIDS. The 1998 KDHS suggests that over 530,000 children are either single or double orphans, but other agencies suggest that the numbers of children orphaned or affected may be as high as 1 million. Evidence suggests that HIV/AIDS orphaned children of unmarried mothers are marginalized and fall outside of clan support and care structures (this may in part explain the difference between KDHS information which is drawn from household members and estimates from other agencies). According to a number of sources, as many as 50 percent of under-three's whose mothers are dying of HIV/AIDS die, whether or not they themselves are HIV seropositive. Stigmatization of HIV/AIDS-affected and infected children is believed to affect quality of, and access to health care. Differences in nutritional and health status have been noted between natural children and fostered/adopted children with girls being more affected than boys. Children living on the street or with a caretaker are less likely to be immunized, educated or have access to healthcare.

- **Child mortality increases*:*** Recent surveys indicate a worsening of child mortality rates during the 1990s, following decades of steady decline. Between 1989 and 1998, under-five mortality rates have increased by 25 percent from 89 to 112 deaths per thousand births. These reversals are most dramatic in Nyanza province where under-five mortality has increased by 34 percent over the same time period. Substantial (20 percent) increases are also found in Coast, Eastern and Rift provinces. Slight improvements in under-five mortality have been recorded in Western and Central provinces

and in Nairobi, although Western province has recorded a slight upturn in recent years. These increases are thought to be due to the expanding HIV/AIDS epidemic in combination with malaria, known to be on the increase and other diseases, since child immunization rates have also fallen throughout this period.

- **Increased demands for health care*:*** The continued increase in the number of women of reproductive age population in Kenya, combined with increasing HIV prevalence and child morbidity means that the demands on the health care system in Kenya will grow rapidly in the years ahead. Experience with public sector health care financing and social marketing indicate that when available at affordable prices, Kenyans are willing to pay for health care. Since public sector health resources are not increasing, building and strengthening cost-recovery systems, including expanding services through private sector providers, are essential if programs are to be able to keep up with demand.

B. CONSTRAINTS

The MTR team identified a number of significant constraints that must be addressed if the APHIA program is to continue to have significant impact on fertility and risk of HIV/AIDS transmission in the face of the issues identified above.

- **Slow pace of implementing health sector reforms:** Progress on reforms appears to have suffered. Many aspects of the reform agenda have been tackled, but few, if any, have been carried out in such a way as to move the reform process forward. The Ministry of Health developed a plan for restructuring the central ministry in 1996. This plan has still not been implemented three years later – and herein may lie the essential constraint to progress. The requisite management team to drive the reform process has been absent during the past five years.

  The situation as viewed from the perspective of service delivery is equally discouraging. Financing and management of public facilities at the service level is deeply troubled everywhere – at the district, provincial and central levels – and the situation appears to be rapidly worsening due in large part to what is perceived in the field to be inaction from headquarters.

  The process of decentralizing the allocation of government resources needs to move forward. Public sector primary health care appears to be deteriorating in many parts of the country. The private sector is expanding rapidly, but in an unregulated manner. This in turn raises serious questions about general quality of care. People are paying increasing amounts out-of-pocket for all types of health care, but considerable amounts of formal and informal cash collections are being diverted and do not benefit the customer. The MOH has made little progress in terms of strengthening its monitoring, supervision, and coordination of research, strategic health planning, resource planning, health care financing and licensing and certification. While the availability of important inputs such as drugs and other resources has improved, physical infrastructure in public facilities is very poor. The day to day operations of the health care delivery systems and services have

been partially delegated to the provincial and district offices through establishment of district and hospital boards. Effective operation of this structure, however, requires further definition of authorities, operational guidelines, and strengthened management capacity.

- **Risks associated with the expansion of services in the private sector:** The 1998 KDHS showed that there is a significant shift away from public sources which now provide contraceptives to only 58 percent of users compared to 68 percent in the 1993 KDHS. The growth of provision of RH services through the private sector will help reduce the burden on the public sector and ensure the sustainability of efforts to reduce fertility and the risk of HIV/AIDS transmission. Currently the private sector is attracting more pill and injectible users than public facilities. However a growing number of service providers who are trained in clinical methods such as IUD insertion are retiring and setting up private practices. Risks of infections and post-procedural complications are a possibility which cannot be ignored. The possibility for supervision and oversight of private practices from the government is limited.

- **Training:** Assessing training results tends to focus on numbers of people trained rather than how trainees are performing. Evaluation of trainee performance is a key to understanding the relative efficiencies and effectiveness of various training approaches which have been developed.

  There are still numerous problems within the MOH supervisory system. Supervisors are not adequately trained. There is insufficient financial and logistical support for carrying out effective supervision. Authorities have not been well defined. For example, trainers assigned to decentralized training centers do not come under the authority of the DHMT and consequently are not routinely invited to be part of teams for supervisory visits.

  Guidelines and standards are developed but not effectively disseminated or utilized. A National Reproductive Health Training plan has been developed but there is no plan or commitments as yet for putting it into effect.

  Training does not appear to have been effective in instilling the fundamental skills and attitudes needed for services providers to function as effective advocates for informed choice and behavior change that result in better reproductive health for their clients. This is reflected in various ways. Service providers do not take advantage of opportunities to introduce family planning to clients. The 1998 KDHS data revealed that among non-users of family planning methods, about one-third (31 percent) had been at a health facility and were not contacted about family planning. Many providers have reservations about discussing sexual behavior with clients – particularly with adolescents – and thus may provide condoms only to clients with STDs. In the face of the rapidly expanded AIDS epidemic, it is irresponsible to provide a family planning method to a female client without also counseling on the need to ensure dual protection.

  There continue to be glaring inequities and inefficiencies in the system for incentives and promotion. Decisions about who is trained and where personnel are deployed are still frequently driven by favoritism and other

factors which do not relate to individual qualifications and needs within facilities.

- **Barriers to behavior change in the face of the growing social and public health disaster posed by the rising AIDS epidemic:** A statement often heard during field visits and key informant interviews is that behavior has failed to change, despite high levels of knowledge about AIDS. The fact that knowledge about condoms is high and use of condoms appears to be increasing must be viewed against the fact that a significant proportion of Kenyans, particularly younger men, continue to engage in behavior that puts them (and their partners) at risk for HIV infection. According to the 1998 KDHS nearly 40 percent of unmarried men aged 20-24 report having more than one sexual partner in the past twelve months. The figure for unmarried men ages 15-19 is 23 percent. Among married men age 20-24 nearly 30 percent report two or more partners, the figure for married males ages 25-29 is 24 percent.

  Respondents have called this "knowledge" highly superficial: people can recite three means of transmitting AIDS and ways of preventing AIDS but this hides the extent of ignorance that still exists. Many people still do not fully understand exactly how AIDS is transmitted by sexual behavior. There is also denial of personal risk and lack of internalization and personalization of the dangers of HIV, even though a high percentage of people now report knowing someone with HIV. Stigmatization of people with HIV/AIDS continues, increasing the likelihood of denial. Cultural practices and norms, including gender issues and power relations, reinforce the barriers to change (particularly to condom use). These norms include adult attitudes towards youth from parents, church leaders, and health providers. The less than committed leadership at many levels of society does not provide a motivating force to counteract this weight of influences that conspire to continue Kenyan society's denial of the socio-economic and personal impact of the epidemic.

- **Limited access of adolescents to services for family planning, STD prevention and control:** The MTR team felt strongly about the urgency of this particular constraint. Adolescents constitute a large segment of the population. Investment in improving their chances for a healthy future also safeguards the future for the country. Improving access in clinical facilities and making them more youth friendly is but one side of the problem. Another side is that adolescents are not frequent visitors to clinics, and thus efforts to reach them in other ways – through schools, youth groups and other places where youth congregate – are equally, if not more, important. Finally, as mentioned above, there has to be a continued effort to influence attitudes on the part of parents, church leaders, adults in general who continue to be unable or even unwilling to consider the realities of adolescent sexual behavior. In greatest need of services are female adolescents, at risk for both HIV infection and for the dangers associated with pregnancy at a young age. Adolescents are targeted under APHIA-supported programs, particularly in HIV/AIDS prevention programs, but more needs to be done.

- **Other gaps in demand for basic health services:** According to KDHS analysis there is much evidence of failure to provide Kenyans with

information about basic reproductive and child health services and convince them to use these services. Here are some examples:

By the sixth month of pregnancy, 40 percent of Kenyan women have not had an antenatal visit

Nearly 33 percent of family planning users discontinue a method within twelve months of starting. Among those who discontinue, about half of pill users and injection users stop because of concerns about side effects or adverse effects on health

Among non-users of family planning methods, fear of side effects is the most frequently cited reason for not using a modern method

Nearly 82 percent of non-users of family planning have neither been visited by a CBD agent nor contacted about family planning during a visit to a health facility

Since the 1993 KDHS, the percentage of children for whom a vaccination card could be produced dropped from 69 percent to 55 percent.

- **Lack of appreciation of the importance of women and children in Kenyan society:** This can be cast in a number of ways – gender, acceptance of the fundamental right of children and women to the means to ensure their good health, empowerment or power relations. In Kenya some formulations raise political hackles more often than others. Whichever way one chooses to cast this formulation, the notion is basically the same: efforts to promote continued reduction of fertility and risk of HIV/AIDS transmission must be underpinned by promoting a fundamental respect for the contribution of women and children toward the prosperity and future well-being of Kenyan society. The lack of this in the current Kenyan societal context is evident in numerous ways:

  The fact that is not unknown for adult males who coerce a female child into having sex to receive light punishment if any sanction at all;

  The evidence of wide-spread physical abuse of women;

  The fact that adolescent girls who become pregnant are frequently forced to drop out of school despite the fact that this is contrary to national policy and further endangers the well-being of their children;

  The fact that many women prefer to use family planning which they can use secretly without having to inform their husbands;

  The fact that malnutrition in children persists at a level basically unchanged over the past five years;

  The fact that the proportion of children who are afforded adequate protection against threatening childhood diseases is significantly less than to five years ago;

  The fact that children under-five and infants are at higher risk of dying compared to five years ago;

The fact that female adolescents are systematically denied access to the best means of protection from the risks associated with pregnancy or HIV/AIDS transmission;

Evidence that children infected and affected by HIV/AIDS are increasingly marginalized -- at risk of malnutrition, illiteracy, disease and death.

- **Other constraining factors in the broader socio-economic context for fertility reduction and risk of HIV/AIDS transmission:** In addition to considering limitations on the rights of women and children it is equally important to consider other constraints to continued fertility reduction and risk of HIV/AIDS transmission. This refers primarily to education and to economic status – particularly at the household and community level. A given level of education and economic status was an implicit assumption in the original APHIA design. Economics and education ultimately figure as two of the most important determinants of fertility levels and child survival. Inability to pay school fees is cited most frequently as the reason for dropping out of school.[4] USAID has recently designed a project for community-based interventions for prevention of HIV/AIDS and home-based care. Caring for persons afflicted with AIDS at home eases the pressure on in-patient facilities. However, such a program must be monitored to ensure that ultimate burden for care does not fall on female children – especially fostered children – who might be kept out of school in order to care for the sick.

  Pregnancy is the second most commonly cited reason for girls dropping out of secondary school. Poverty must be considered among the factors inducing young girls to become sexually active, particularly when exchanging sex for favors may mean the difference between having enough to eat or going hungry.

  Finally to be considered is the emphasis on having communities assume greater responsibilities for financing health care. Care must be taken first to be certain that the communities have sufficient financial (and human) resources to play an increasingly more prominent role in financing health care.

  With GNP growth slowing from 4.8 percent in 1996 to 2.3 percent and 1.6 percent in 1997 and 1998 respectively, this translates into grim prospects for the potential of households and communities to take on an increasing share of financing primary health care. Viewed against the backdrop of a population growth rate which is estimated at between 2.0 and 2.5 percent, and the slowing down of the agricultural sector in general (in areas where USAID programs have undertaken many activities), the prospect seems to be growing that families will increasingly face the choice between eating or paying for basic health care and school fees.

[4] According to the 1998 KDHS, inability to pay school fees is the most frequently cited reasons for girls dropping out of school.

- **Limitations in various approaches for delivering services: the role of clinics and CBD (and other outreach) services:** The issues paper on reproductive health service delivery notes that CBDs supply 3.4 percent of all modern family planning methods and observes that CBDs are an effective way to reach persons living in remote areas. The fact that the population of Kenya is still predominately rural is a reason to consider that CBD programs (for the near future at least) could still be considered as an effective, if expensive, way to reach people living in more remote areas. There are still questions to be answered about effective ways to structure CBD programs.
- **Supply of necessary supplies and commodities:** Reliable sources for condoms, other contraceptives, STI drugs, other essential drugs and vaccines do not exist and future donations are uncertain. Kenya faces serious deficits in contraceptive supplies over the next five years. This is particularly critical regarding future supplies of condoms. Neither the donors nor the GOK have a clear strategy to secure reliable sources of these supplies for the long term.
- **Funding from other donors:** The health sector in Kenya relies heavily on donor contributions. Future donor funds are not likely to rise. Some donors are closing programs in Kenya, others plan to maintain present level of funding or decrease funds. This constitutes a change in a major assumption made about the health sector environment since the original APHIA design.
- **Funding from USAID:** USAID programs in Kenya have already undergone one drastic funding cut with results referred to in this report. Funding was restored to about two-thirds the level envisioned in the APHIA design. The prospects of increasing USAID funding for health activities are unlikely. The possibility that funding would be reduced in future can not be ruled out. USAID will have to do more in future with the same level of funding.
- **APHIA Project management:** The project at present is a combination of a number of activities which have been brought together under a results framework. It entails several cooperative agreements, a contract, field support transfers to centrally funded projects, and core-funded activities. With a large number of office staff and frequent visits from TDY consultants, there is bound to be some duplication of effort and difficulties with coordination. The issue related to integration of activities under the rubric of reproductive health interventions has already been mentioned. Two other cases in point are AVSC and JHPIEGO training activities and IEC activities through the various grantee organizations. AVSC and JHPIEGO are working with similar new training methodologies and trying to address problems related to supervision and assessment of the impact of training, yet there seems to be little evidence that either of these organizations spend much effort on sharing information. IEC activities to date as well, particularly since the demise of the IEC working group, can also be characterized as poorly coordinated. The MOH has voiced some dissatisfaction with the number of consultants coming in and out who are connected with the project. Difficulties with the BDI project have also been documented in this report.
- **APHIA performance monitoring:** Cooperating agencies working on service delivery are apparently not working from common definitions of new users and continuing users, nor do they appear to report against the same

benchmarks or indicators. It is difficult in considering the APHIA project as a whole to get a sense of the number of direct beneficiaries of services and how these beneficiaries are benefiting from APHIA activities. This is especially true for vulnerable groups such as children and adolescents. The proportion of fever cases adequately treated for fever is the nearest to reporting actual impact for child beneficiaries under the BDI project. There is no disaggregation of indicators on fertility, contraceptive prevalence, or condom use which present impact for adolescents.

There is dissatisfaction with the current indicator being used to report on impact of HIV/AIDS prevention activities. Part of the problem is that at a minimum, data should be disaggregated to make the information more meaningful. There are distinctive differences in sexual behavior among the different age groups that are not captured by reporting on everyone between the ages of 19 and 49.

C. RECOMMENDATIONS

- **Build on USAID's existing strengths and experience:** The mid-term review team agreed unanimously that this should be an over-arching principle underlying APHIA programming through the year 2005. APHIA should continue to build on 20 years of successful USAID experience in delivering family planning services. This includes systems for supporting service delivery: training, policy and advocacy, IEC, commodities and logistics.

- **Adopt a geographic focus:**
  What would it entail? USAID would identify target districts within a limited number of provinces, two or three at most. Although specific districts would be targeted, the overriding perspective is a community-based approach. The interventions would focus on service delivery for reproductive and child health. This includes supporting systems such as policy, commodities management, training, IEC and advocacy for recognition of the rights of women and children.

  In addition attention is also paid to the community context, that is to say all the important determinants of fertility and risk of HIV transmission – education economic status (of households and communities), along with any other important societal and cultural determinants. These factors should be closely monitored. While USAID would not directly address all of these needs, it should be prepared to ensure that somehow these needs are addressed. This could take several forms:

  Co-programming with other donors

  Co-programming with other offices within the USAID/Kenya mission (food security programs with ABEO or democracy and governance grants with the Program office)

  Advocacy with district and provincial officials to ensure that problem areas receive priority for programs and funding.

  USAID assistance would support activities at all levels: community, district, provincial and national. The idea is to ensure that the district health management team is technically capable of overseeing and supporting RH

and child health activities within the district and that the district hospital functions adequately as a referral facility. Assistance at the provincial level is much the same as at the district level – to ensure that the provincial hospital functions adequately as a referral facility for districts and communities within the province and that the provincial health management team is technically capable of providing oversight and guidance for RH and health activities within the province.

USAID assistance at the national level would be much the same as it has been – to ensure that the requisite policies, guidelines, professional standards etc. are in place, disseminated and implemented to support service delivery and supporting systems at the provincial, district and community levels.

In brief, APHIA through the end of 2005 would mirror the original design – with the components for IEC and district focus reintroduced. It is no longer possible for APHIA to continue to try to be a national program given the present funding constraints and the ever-present possibility of more funding cuts. Though the program at the national level would look much the same as it does now, this would mean that most CA programs would be supported only in geographic focus areas.

Why a geographic focus? The nature of activities proposed requires close monitoring and evaluation. The proposed behavior change interventions rely heavily on interpersonal communication techniques and must be closely supervised and monitored. The proposed focus on the community systems will also require close monitoring to assure that all processes and factors are well understood. Close monitoring and evaluation of impact is also needed in order to document successes and failures and to develop realistic objectives and targets as the model is developed for replication elsewhere.

What areas would be targeted? The review team discussed a number of selection criteria for provinces and districts

- Provinces showing increases in child/infant mortality, lower fertility than the national average and high HIV prevalence.
- Focus areas for activities already being supported under APHIA – examples: FHI/Impact focus areas, Bungoma (to build on successful experiences with IMCI)
- KDHS focus districts – where baseline information is already available for key indicators tracked under APHIA
- Areas targeted for assistance under the cooperative agreement for community-based HIV/AIDS care and support awarded in May 1999

Pros and cons of specific provinces have been discussed. The three possibilities most often discussed were:

- Coast Province – Work on upgrading financial and management systems within the hospital is already underway. This is also a focus area for FHI/Impact and the recently awarded cooperative agreement for community-based HIV/AIDS care and support. Infant/child mortality and TFR are higher than the national average. There are significant constraints to achieving rapid successes. Community financing

initiatives have been problematic in this area. Conservative attitudes about the rights of women and children are deeply entrenched. However, working in this province offers the possibility of developing a successful model for working in predominantly Moslem communities.

Western Province – Bungoma district is situated here. There would be an opportunity to build on successes working with IMCI at the facility level. This would also afford the opportunity to continue building on malaria research. Western Province is also an area showing high infant/child mortality and TFR compared to national average.

Nyanza Province – This is a densely populated province with potential for high impact. This has the highest HIV/AIDS prevalence in the country. Other health indicators – TFR and infant/child mortality – are higher than the national average. Nyanza is also a center for a great deal of research. The major disadvantage is the presence of so many other donor and NGO programs. Coordination and avoiding duplication would be very difficult.

Central Province – while fertility is lower than the national level and use of modern contraceptive methods is higher, surveillance data shows alarming increases in HIV prevalence.

Final selection would depend of course on discussion with the MOH.

- **Advocate within the Mission for adoption of a geographic focus across all programs:** The possibilities for co-programming have been referred to above. It may not be possible to maintain 100% congruence of geographical targeting across all programs – especially in the case of DG. USAID/Kenya could consider setting targets within the various offices once geographic areas are agreed upon. This would mean that ABEO and DG would agree to concentrate a fixed percentage of activities in focus areas.
- **Continue working with the GOK to advance the process of implementing health sector reforms:** USAID should continue its collaboration with other donors and the Ministry of Health in the preparation of the National Health Sector Strategic Plan. APHIA should also collaborate with other donors and the Ministry of Health to develop a plan of action for strengthening the management capacity of the Ministry's reform team, including senior central and provincial managers, headed by the Permanent Secretary that will drive all aspects of the reform process.

  It should be noted here that the newly constituted senior management team within the MOH recently convened a meeting with donors in which the MOH laid out its views on problem areas and priorities. This was an encouraging step in the direction of restoring confidence with donors. It now appears that the MOH may have the requisite management team in place to address critical problems within the health sector.

  USAID should also continue working on cost-recovery and community financing initiatives drawing from successful models developed elsewhere. APHIA should use experience at the community level to inform the process of setting policies and procedures at the provincial and national levels.

- **Work with the GOK to maintain quality control as service delivery expands in the private sector:** This entails working with the MOH at the national and local levels to further refine the regulatory framework for oversight of service delivery in the private sector.
- **Integrate child survival interventions more concretely into APHIA and focus on the child rather than on interventions:** USAID should introduce indicators which focus on benefits to child beneficiaries – such as immunization rates and, if feasible, infant and child mortality. Define targeted age groups. Continue district-level IMCI with focus on malaria and get communities more involved in understanding IMCI and implementing IMCI at the household level. Continue to focus on VII
- **Continue to work with the MOH to address issues related to training:** USAID should facilitate the development of a stakeholders group in support of training to share information and avoid duplication of effort. NASCOP should be included in this group. Consider ways to better operationalize the training information management system. Consider making the implementation of policies on selection and deployment of MOH staff a conditionality in the next agreement mechanism. Support a study to analyze effectiveness and efficiency of various training methods now being explored under APHIA. Focus more attention on skills training for supervisors. Support training which is aimed at changing provider attitudes and practices which limit access to health care and information. This includes having service providers become more proactive in providing information about STD prevention and family planning to clients, especially to adolescents. Shift the emphasis in evaluation of training to assessment of competence and reduction of provider biases which limit access to health services.
- **Reinstitute IEC as a strong APHIA project component and broaden to include additional messages to support improved reproductive health:** Revive the IEC working group among USAID funded CAs as a means to establish more coherence in IEC activities. The responsibility for coordinating the group could be undertaken either by USAID or by one of the CAs. However, previous experience in vesting this responsibility with a cooperating agency was not successful. In order to work, this must be driven by USAID.

  USAID should also encourage the MOH to revive an IEC working group which would be comprised of donors and key MOH divisions and departments (DPHC, DSHC, NCPD, NASCOP).

  IEC focus should be recast as behavior change communication and emphasize behavior change interventions based on interpersonal communication – peer education and counseling, reducing biases among service providers. However, mass media and audio-visual materials should continue to be used where appropriate.

  Social marketing techniques should be more integrated into IEC processes. This means more differentiation of messages and targeting specific audiences.

APHIA should consider emphasizing a grouping of IEC messages to go beyond RH to include child health and other determinants of fertility and risk of HIV transmission. These might include:

- Keep children (especially girls) in school
- Encourage younger children (both boys and girls) who have not yet become sexually active to postpone their sexual debut
- Encourage those adolescents who have become sexually active to use dual protection if possible
- Encourage women to use dual protection
- Encourage men to use condoms more consistently
- Encourage younger, unmarried men with multiple partners to use condoms always or at least to seek voluntary testing for themselves and partners
- Reduce stigma associated with STDs, especially HIV/AIDS
- Encourage communication about sex and protection between partners.
- Encourage women to seek antenatal care
- Encourage mothers to obtain full immunization coverage for their children
- Allay fears about side effects of hormonal methods
- Advocacy to reduce cultural barriers which impede the access of women, children and adolescents to basic health care

- **Revisit CBD programs and examine potential for adapting successful models from other countries**

CBD agents sometimes cover areas of up to 200 households. It is not reasonable to expect a volunteer to cover this many households and do it effectively. Some alternatives to consider follow:

- Maintain the program with mobile CBD agents but reduce the number of households to be covered
- Have CBD agents work from stationary positions as “depot holders.”
- Have CBD agents work more through networks and groups rather than house to house.
- Train CBD agents take on more responsibilities beyond family planning, and basic STI counseling and referral to include basic child health. This would entail higher minimum education for CBD agents – at least secondary level or perhaps trained pharmacists – and would probably require re-thinking incentives. CBDs could then recruit and supervise networks of volunteers who in turn work through groups.

USAID should undertake a study to assess relative cost-effectiveness of various CBD models undertaken in Kenya to date and make suggestions based on experiences of other models in Asia and Latin America.

- **Commodities:** Undertake a study to get an independent determination of national requirements for RH commodities. Use this study as the basis for developing a national strategy that can address long- and short-term scenarios and propose solutions.
- **Project management** USAID should consider ways to reduce the number of cooperating agencies working in training and service delivery. USAID should also consider combining service delivery with training, since they are more difficult to assess as individual elements. USAID should take a stronger role in coordinating training activities to avoid duplication of effort and encourage CAs to share information on processes and tools for assessing performance of trainees. USAID should also take a stronger coordinating role in service provision to avoid repeat of the experience growing out of cuts in supervision of CBD programs. CAs should be encouraged to cut back geographic scope of activities rather than cut support for supervision.

  APHIA could consider exploring a management model which entails accessing services of an organization through a central contract or cooperative agreement. The organization in turn becomes responsible competing and managing sub-grants. Experiences with this model in other Missions and offices have been mixed. Success depends on interpersonal skills and willingness to make the arrangement work within the management team. USAID-funded CAs often express difficulties in trying to reconcile the push from USAID to share information and cooperate in the interest of development with the pull from USAID to be competitive and innovative.

  Accessing TA through centrally-funded projects also has its advantages and disadvantages. For most projects, CAs offer long years of experience and often a global perspective which brings the benefits of experiences and models from other countries. On the other hand, processing procurements and/or amendments through the AID/W contracts office can be difficult and time-consuming. Assistance is limited by the amount of time remaining on the funding mechanism.
- **Project monitoring and evaluation:** USAID should revisit the following targets and indicators:

  Capacity building in the private sector: Settle on an indicator which best describes impact of work in the private sector.

  CPR targets: review the original underlying technical assumptions and try to assess and quantify factors contributing to the slowdown in CPR. This should be a subject of follow-on analysis to the KDHS. Questions which USAID could consider are: Is this slowdown typical at this level of contraceptive prevalence in other countries in Africa, Asia or Latin America? Is there a possibility of the HIV/AIDS epidemic contributing to this phenomenon – e.g. rising level of abstinence which is not reported as family planning? USAID also needs to take care to insure uniformity and consistency in phrasing the indicator and baseline. There are differences across reporting documents. There are questions as to whether the baseline figure is based on CPR of married women, while the indicator now states that CPR is considered for use of modern

methods by all women; and whether SPECTRUM calculations for estimating annual CPR targets are based on married women.

CYP targets for USAID grantees: develop realistic new targets. Consider the possibility that as the HIV epidemic expands, condoms may comprise a rapidly growing share of CPR. CYP targets may have to be revised accordingly.

National CYP targets: CYP targets could be affected if the program moves to increased emphasis on condoms. Although national CYP is on track, there is some evidence pointing to a possible slowdown. USAID should examine this further.

More effective method mix: Built into the APHIA design was a perception of the Kenya family planning program as "maturing". For "mature" family planning programs, the common approach in USAID-wide programming is to talk about a more effective method mix which generally entails emphasizing permanent and long-term methods: vasectomy, tubal ligation, IUDs, implants and injectibles. This objective needs to be balanced against the reality of a rapidly rising HIV prevalence. The call for "dual protection" implies a need to revisit this objective and/or targets.

Impact of HIV/AIDS activities: If USAID decides to adopt a geographic focus, explore the feasibility of using data on incidence to report on impact of HIV/AIDS activities at the district (or provincial level).

Generally USAID should revisit the results framework to include more emphasis on impact to beneficiaries This includes disaggregation of data by age and gender.

USAID should also consider undertaking an interim household survey, between KDHS, to assess progress toward achieving desired impact for project beneficiaries and to monitor other socio-economic factors related to fertility and child survival. This household survey should be linked with service provider assessments. USAID should also consider ways to reduce survey costs. This includes soliciting support from other donors and making a greater effort to identify surveys conducted by other donors and agencies which provide useful information to establish baselines and targets. Using techniques from lot quality assessments in surveys – setting threshold targets, e.g. at least 60% of providers performing to a set standard or at least 60% of households adequately managing fever in children -- can reduce sample size and thus further reduce costs of surveys.

Attachment A: MODEL FOR GEOGRAPHIC FOCUS

DIVISIONAL AND LOCATIONAL LEVEL –
Objectives:

- **Improved reproductive and child health of community members**
- **Improved capacity within communities to support community health initiatives**
- **Greater appreciation of rights of women and children to optimal health**

- *Training in clinical and counseling skills for health workers in RH (private and public sector)*
- *Training in IMCI with focus on malaria*
- *Training in financial management*
- *Training in management of commodities*
- *Training in advocacy and IEC skills for working in communities*
- *Advocacy for improved status of women and children*
- *Documenting successful models of community financing*
- *Community outreach programs which include behavior change interventions*
- *Monitoring program impact within communities – i.e. community surveys and service statistics from health facilities and outreach programs*
- *Monitor impact of determining factors which are not directly addressed under APHIA*

Outside of APHIA

- *Rehabilitation of physical infrastructure**
- *Addressing trends in education, economic status, other determining cultural factors*

DISTRICT LEVEL
Objectives:

- **District hospital functions adequately as a referral facility**
- **District administrative structures adequately support community health initiatives – this includes assuring that DHMTs monitor adequacy of programs for schools, infrastructure, economic development**
- **Districts capable of coordinating NGO and donor activities**

- *Training for strengthening managerial capacity – including governance training for management boards*
- *Training in financial management*
- *Training in IEC and advocacy skills*
- *Monitoring impact of interventions at district level (aggregate results of community surveys, service statistics from health facilities)*
- *Cost-sharing improvements in district hospital*
- *Advocacy for improved status of women and children*
- *Support for maintaining commodities supplies*
- *Support for supervision and monitoring of RH and child survival services*
- *Monitor impact of other determining factors which are not directly addressed under APHIA*

Outside of APHIA

- *Rehabilitation of physical infrastructure*
- *Addressing trends in education, economic status, other determining cultural factors*

PROVINCIAL LEVEL

Objectives:

- **Provincial hospital functions adequately as referral facility**
- **Provincial health team provides adequate technical oversight for services at the district and community level**
- **Province capable of coordination and oversight of donor/NGO activities**

- *Training for strengthening managerial capacity – including governance training for management boards*
- *Training in financial management*
- *Training in IEC and advocacy skills*
- *Monitoring impact of interventions at provincial level (aggregate results of community surveys, service statistics from health facilities)*
- *Cost-sharing improvements in provincial hospital*
- *Autonomy of provincial hospital*
- *Advocacy for improved status of women and children*
- *Support for maintaining supply of commodities*
- *Support for supervision and monitoring of RH and child survival services*
- *Monitor impact of other determining factors which are not directly addressed under APHIA*

Outside of APHIA

- *Rehabilitation of physical infrastructure*
- *Addressing trends in education, economic status, other determining cultural factors*

NATIONAL LEVEL

Objectives:

Policies and systems are in place to support activities at the provincial, district and community level

- *Support for developing and disseminating professional guidelines and standards for training and services*
- *Support for implementing national training plan*
- *Support for implementing health sector reform in targeted areas*
- *Support for developing standards for services in the private sector*
- *Monitor impact of other determining factors which are not directly addressed under APHIA*

Outside of APHIA

- *Rehabilitation of infrastructure*
- *Addressing trends in education, economic status, other determining cultural factors*

Attachment B: PROPOSED AMENDMENTS TO THE PERFORMANCE MEASUREMENT PLAN

Shading denotes suggestion to drop text. Underlining denotes suggestion for adding text.

RESULT	INDICATOR	DISCUSSION AND RECOMMENDATIONS FOR CHANGES
Reduce fertility and the risk of HIV/AIDS through sustainable, integrated family planning & health services	Total fertility rate Use of condoms with non-regular sexual partners (% of 15+ and women 15-49 using condoms with non-regular partners in the last six months	Continue TFR Consult current reporting by NASCOP, UNAIDS recommendations and USAID guidance on HIV/AIDs indicators. Disaggregate data to report on all women/men and women and men ages 15-19. First choice should be to align with government reporting and indicators, but consideration needs to be given on current discussion on indicators within UNAIDS and thinking/guidance within USAID
1.0 – Non-USAID financial resources for FP, HIV/AIDS and CS increased	GOK multi-year plans for FP/HIV/AIDS/CS services developed	Continue to use the POLICY AIDS environment score OPH is considering developing an index score (SWAP) for describing progress in other areas – CS, FP – which would be similar to the POLICY AIDS environment score. Another possibility would be to develop a matrix of benchmarks and score by % achieved. The first possibility is a more objective assessment which would be based on results from polling approximately 40 agencies, then analyzed by OPH. The second possibility is less time intensive but more subjective.
1.1 – Collaboration with major European donors and Japan intensified	Selected donor expenditure for complementary FP/HIV/AIDS and CS activities increased. Intensity of collaboration with major European donors and Japan	Continue to report qualitatively. Compile information from minutes of meetings, etc. Consider using a reporting matrix – an annual workplan with each agency and report against a % achieved of workplan benchmarks or milestones.

RESULT	INDICATOR	DISCUSSION AND RECOMMENDATIONS FOR CHANGES
1.2 – Sources of funding for USAID FP service delivery programs diversified	Non-USAID financing for service delivery NGOs increased	This sub-IR does not appear to figure regularly in R4 reporting – drop it.
2.0 – Capacity of public and private health institutions to finance, plan and manage resources increased	Annual MOH cost-sharing revenue increased to US $10 million by 2000 Per capita financing of health care increased Cost-sharing revenue as a proportion o f the annual MOH non-wage recurrent budget increased from 13.2% in 1994/95 to 25% in 2000 Add an indicator which accounts for progress working with private sector institutions	Of the three results 2.0, 2.1 and 2.2. OPH appears to report most regularly on 2.0 using cost-sharing revenue. Drop the shaded indicators. They don't appear as part of R4 reporting since 1997. Consider developing a matrix which would be used to report on progress in developing financial and mangement plans – give a score of % of targets achieved. Explore possibilities for using AFS reporting against targets specified under the contract.
2.1 – Public sector financial resources for primary and preventive health-care increased	Percentage of revenue (including cost-sharing) retained at sub-district levels increased from 25% in 1994/95 to 50% Number of people covered through private health insurance and HMOs increased	Drop this sub-IR and indicators. This does not appear as part of regular R4 reporting.
2.2 – Organizational capacity and self-sufficiency of key private sector FP and HIV/AIDS service providers improved	Number of specified NGOs with cost-recovery mechanisms in place increased Percentage of recurrent costs recovered through cost-recovery increased Demand from NGO boards and management for assistance in strategic planning increase	Drop this sub-IR and indicators – does not appear as part of regular R4 reporting.

RESULT	INDICATOR	DISCUSSION AND RECOMMENDATIONS FOR CHANGES
3.0 – Increased customer use of integrated FP/HIV/AIDS/CS services	Contraceptive prevalence rate for modern methods increased among all women from 21% in 1993 to 38% by 2000 Trust condom sales increased from 2 million in 1994 to 3.5 million in 2000 Trust condom sales increased from 200,000/monthly in 1994 to 1.5 million/monthly by 2000 National CYPs	Review SPECTRUM analysis which projects targets for this indicator. There is a possibility that analysis has been based on prevalence of modern methods among married women. Revise wording and unit of measure from the performance monitoring plan which is still based on projections for annual sales. Revise projected targets for condom sales per discussion in Social Marketing Issues Paper – international experience shows that mature programs experience about a 15% annual increase. This is less than current projections. National CYPs figure as part of regular reporting but do not appear on the current Performance Measurement Plan . This indicator should be added. Though on target, national CYP uptake appears to be slowing. CYP grew by 500000 from 1994 to 1997, an average of 167,000 per year. CYP was expected to grow by 300,000 between 1997 and 1998. It grew by 100,000. Annual targets to 2000 show expected annual increases of about 200,000. Re-examine assumptions and adjust targets if needed.
3.1 – Policies and program approaches for FP, HIV/AIDS and CS services improved through research, analysis, monitoring and evaluation	Number of annual AIM presentations increased Family planning projections updated and disseminated The KDHS completed and disseminated by 1999 A functional OPH M&E systm developed	Develop a matrix for each research/policy organization showing planned activities and % completed. The respective CAs could be responsible for including this in quarterly reports. Consider also the possibility of developing a index rating based on polling among various MOH offices, CAs and other organizations which use USAID-funded study and survey results. This could be administered bi-annually and done either within OPH or contracted out. OPH is considering dropping the shaded indicators.

RESULT	INDICATOR	DISCUSSION AND RECOMMENDATIONS FOR CHANGES
3.2 – Prevention and management of childhood illnesses including malaria improved in a target district in target areas	Appropriate treatment protocols for drug-resistant malaria developed & implemented Proportion of households using insecticide treated materials Proportion of fever cases childhood illnesses effectively treated Training curriculum for integrated management of childhood illnesses developed and in use No. of health workers trained on integrated management of childhood illnesses	Phrasing of this objective wouid have to change if USAID adopts the recommendation to go to a geographic focus. Adding the word 'implementation' focuses attention on evaluating treatment at facilities. This should be part of supervision. Assessing use of insecticide treated materials, management of fever cases should be part of household surveys. Rewording this indicator adds flexibility for focus on whatever childhood illness is most relevant in the area, e.g. ARI for Central Province or malaria for Coast, Western or Nyanza Provinces. The proportion of childhood illnesses effectively treated should be monitored both in facilities and at household level (as IMCI develops a program for household management of child illnesses). Results should be geographically linked. Drop development of training curricula and # of health workers trained – these are inputs.

RESULT	INDICATOR	DISCUSSION AND RECOMMENDATIONS FOR CHANGES
3.3 – Key FP and HIV/AIDS service delivery support systems strengthened and institutionalized	Proportion of SDPs maintaining an adequate supply of low-dose pills and condoms increased – target is 90% adequacy at 80% of SDPs Targets are met for annual no. of FP service providers receiving refresher training National FP logo adopted and launched	This is an appropriate and descriptive indicator for reporting on impact of assistance in logistics management. It is regularly used in program reporting and should be retained Trained service providers are an input – a more relevant measure is one which looks at % of trained providers who perform adequately as evaluated against performance standards. Considering provider performance is the most meaningful way to assess whether funds for assistance to work on performance standards, national training information systems, etc. have been well-spent. A great deal of funds have directly supported training in the past and yet provider attitudes and practices continue to pose a significant barrier to access of services for all clients. The regular service provider assessment (KSPA) provides useful information on performance of service providers but this is an expensive survey and is conducted infrequently. Providers should be evaluated and receive feedback on performance continually. Consider ways to operationalize current JHPIEGO work on assessing trainees using an index. The national FP logo has now been launched. USAID needs to look at more meaningful measures of IEC effectiveness. Behavior change (use of condoms, use of FP is considered at a higher level). At the sub-IR level, effectiveness could be evaluated in terms of % of respondents who retain key messages or information

RESULT	INDICATOR	DISCUSSION AND RECOMMENDATIONS FOR CHANGES
3.4 – Integrated FP and HIV/AIDs services provided by selected NGOs and CAs	Number of sub-locations receiving CBD services increased from 3700 in 1995 Increased number of VSC sites Service delivery sites providing integrated FP/HIV/AIDS services CYP in USAID-funded programs increase from 400,000 in 1994 to 850,000 by 2000 Increased proportion of contraceptive users in USAID-funded programs using long-term methods	It has not been possible to get a good sense of USE of facilities from current information in the SD paper. Experience shows that the number of facilities is expanding, yet the question needs to be asked whether these facilities are being used. This appears to be an important question in the case of FPAK. Consider requiring CAs to report on use of services – new acceptors and also continuers (current thinking is that continuation is a good measure of CBD performance). CYPs in USAID funded programs is not regularly reported in R4s but is a useful service statistic. Proportion of users using long-term methods is also not part of regular reporting to AID/W but is a helpful measure of impact and check against CYPs.
3.5 – Current: Increased availability of effective, gender sensitive, HIV/AIDS responses in selected populations	Strengthened capacity of key stakeholders to build an enabling environment for HIV/AIDS/STI prevention and care activities Improved capacity of selected communities to identify their needs and develop, coordinate and implement appropriate HIV/AIDS/STI prevention and care activities Improved capacity of public and private institutions to increase demand for and deliver quality HIV/AIDS/STI prevention and care services	This purpose still reads “Use of improved, effective and sustainable responses to the HIV/AIDS epidemic increased” in the performance measurement plan. It needs to be changed. OPH may also consider merging each of these into other IRs and Sub-IRs. Move the first into IR #1. Move the second into sub-IR #3.3. Develop this indicator as an index which includes assessment of changes in status of women and children. Move the third into sub-IR #3.4. Develop an index which includes assessment of changes in attitudes of service providers.

ANNEX A: MEMBERS OF THE CORE TECHNICAL TEAMS

CHILD SURVIVAL
Sarah Jones, CAFS consultant
Victor Masbayi, OPH
Mary Ettling, AID/W
Alix Grubel, REDSO

HEALTH SECTOR REFORM
Helena Kithinji, CAFS Consultant
Milly Howard, OPH
Roberto Esposito, European Union
Joseph Ondigi, CONT
Emma Njuguna, OPH

HIV/AIDS
Neen Alrutz, OPH
Esther Ndiangui, OPH

IEC
P. Kibiriti, CAFS Consultant
Jerusha Karuthiru, OPH
Janet Hayman, REDSO
Michelle Folsom, REDSO

REPRODUCTIVE HEALTH SERVICE DELIVERY
Aloys Ilinigumugabo, CAFS Consultant
Mike Strong, OPH
Emma Njuguna, OPH
Timothy Takona, OPH
Margaret Makumi, MOH

REPRODUTIVE HEALTH LOGISTICS
Naomi Blumberg, AID/W
John Wilson, JSI (Ex officio team member)
Jerusha Karuthiru, OPH

SOCIAL MARKETING
Mike Strong, OPH
John Berman, PSI (Ex officio team member)

TRAINING
Sarah Kaviti, CAFS Consultant
Elizabeth Kizzier, OPH
Melinda Wilson, REDSO

ADDITIONAL MEMBERS
Barbara Dickerson, Team Leader
Scott Radloff, AID/W
Dana Vogel, OPH
Lucy Mogeni, OPH
Mary Mujomba, CAFS Consultant

ANNEX B: MEMBERS OF FIELD TEAMS

TEAM 1 Destination: Busia/Kakamega	TEAM 2 Destination: Nyeri/Muranga
Sarah Jones, CAFS Melinda Wilson, REDSO Emma Njuguna, OPH Jerusha Karuthiru, OPH Joseph Ondigi, CONT	Sarah Kaviti, CAFS Janet Hayman, REDSO Milly Howard, OPH Alix Grubel, REDSO Margaret Makumi, MOH Naomi Rutenberg, AID/W
TEAM 3 Destination: Kisumu/Siaya	TEAM 4 Destination: Mombasa/Kilifi
Peter Kibiriti, CAFS Aloys Ilinigumugabo, CAFS Mary Ettling, AID/W Mike Strong, OPH Roberto Esposito, EU	Helena Kithinji, CAFS Victor Masbayi, OPH Michelle Folsom, REDSO Tim Takona, OPH Liz Kizzier, OPH

ANNEX C: LIST OF STAKEHOLDERS CONSULTED

KEY INFORMANT INTERVIEWS IN NAIROBI

Child Survival

1. Dr. M. Hassan, Director, Division of Primary Health Care
2. Dr. Sarah Onyango, Manager, KEPI, Division of Primary Health Care
3. Ms. Joy Opumbi, Program for Integrated Management of Childhood Illnesses, Division of Primary Health Care,
4. Ms. Benta Shako, Chief Nutritionist, Division of Primary Health Care
5. Earling Larson, Advisor to KEPI, DANIDA
6. Alberto Gallacchi, Advisor, Health Sector Support Programme
7. Ian Sliney, Chief of Party, Management Sciences for Health
8. Dr. Alistan Unwin, DFID
9. Jason Lane, Programme Officer, DFID
10. Dr. Kariuki, Health Planning Management Unit, AMREF
11. Dr. John Ndube, Health Planning Management Unit, AMREF
12. Ms. Jane Gitonga, Division of Primary Health Care
13. Mrs. Margaret Muiva, Chairman Department of Nursing, University of Nairobi
14. Mr. Ole Kiu, Chairman, Clinical Officers Association
15. Chairman, University of Nairobi Community Health Department
16. Dr. Muge, Infectious and Communicable Diseases, WHO
17. Dr. Tabitha Oduori. , WHO
18. Don Dickerson, HAPAC Project, Futures
19. Swaleh Karanja, CARE-Kenya
20. Dr. Grace Miheso, CARE-Kenya
21. Dr. Marinus Gotink, Health and Nutrition Officer, UNICEF
22. Jane Kariuki, Nutritionist, UNICEF Kenya
23. Helena Eversole, UNICEF Kenya
24. Kimberley Gamble-Payne, Senior Rights Officer UNICEF Regional Officer
25. Francis Farmer, Director of Programming, Pathfinder

Health Sector Reform

1. Management Sciences for Health
2. HEROS (Dr. A Kaburu, Patrick Njue)
3. Health Care Financing
4. Aga Khan Foundation (Nazira Jaffer, Len Heffner)
5. Community Based Health Initiatives (Dr. Joyce Onsongo)
6. NCPD (Karuga Ngathia)
7. IPPF (Jane Kwawu)
8. DANIDA
9. GTZ
10. CIDA Canada
11. The World Bank
12. Family Planning Association of Kenya
13. AAR Health Services

IEC

1. Mr. Mucheke, FPAK
2. Emily Obwaka, JHU/PCS
3. Dan Odallo, JHU/PCS
4. Dr. Linus Ettyang, NCPD
5. George Kahuthia Samson, PATH/KENYA
6. Esther Gatua, KANCO
7. Dr. Bilha Hagembe, NASCOP
8. Meshack H.O Ndolo, NASCOP
9. Dr. Tom Mboya Okeyo, NASCOP
10. Michael Welsh, FHI
11. Jessica Price, FHI
12. Janet Hayman, USAID/REDSO/ESA
13. John Berman, PSI
14. Dr. Margaret Makumi, DPHC
15. Michael Wamae, MAP INTL
16. Dr. Henri Van der Homberg, GTZ
17. Willy Nyambati, JICA
18. Roberto Esposito, EUROPEAN UNION
19. Jayne Kariuki, UNICEF
20. Chaacha Mwita, Nation
21. Eunice Obingo, UoN

Reproductive Health Logistics Management

1. Dana Vogel, OPH
2. Neen Alrutz, OPH
3. Jerusha Karuthiru, OPH
4. Michael Strong, OPH
5. Milly Howard, OPH
6. Elizabeth Kizzier, OPH
7. Timothy Takona, OPH
8. Michelle Folsom, REDSO/ESA
9. Janet Hayman, REDSO/ESA
10. Alix Grubel, REDSO/ESA
11. Melinda Wilson, REDSO/ESA
12. Dr. Makumi, MOH/DPHC
13. Anthony Ophwette, Head LMU/MOH/DPHC
14. Helena Perry, SIDA
15. Ann Njeru, SIDA
16. Caroline Sargent, DFID
17. Wacuka Ikua, World Bank
18. Sheila Embonguo, UNFPA
19. Charlotte Larsen, UNFPA

Reproductive Health Service Delivery

1. Mr Lewis Ndhlovu, Population Council
2. Dr Jane Chege, Population Council
3. Mr Charles Tube, Pathfinder International
4. Ms Pamela Onduso, Pathfinder International
5. Mr Gilbert Magiri, Pathfinder International
6. Ms Irene Mwaponda, Pathfinder International
7. Mr Mucheke, Family Planning Association of Kenya
8. Dr George Muriithi, Family Planning Association of Kenya
9. Mr Siniwa, Family Planning Association of Kenya:
10. Dr Michael Welch, Family Health International
11. Mr John Wilson, Family Planning Logistics Management Unit
12. Mr David Karite, Family Planning Logistics Management Unit
13. Dr Margaret Makumi, Division of Primary Health Care
14. Dr Sabine Bekkermann, GTZ Project
15. Mr John Berman, Population Services International
16. Ms Veronica Musembi, Population Services International
17. Ms Dorothy Hodson, Population Services International
18. Mr Feddis Mumba, AVSC
19. Ms Rose Wahome, INTRAH/ PRIME
20. Mr Charles Nyaberi, Marie Stopes Kenya
21. Ms Martha Mutunga, Marie Stopes Kenya

Training

1. Jane Gitonga - Senior Trainer, Ministry of Health/Division of Primary Health Care
2. Melissa Mulimba – Trainer, Ministry of Health/Division of Primary Health Care
3. Margaret Ngure - Chief Nursing Officer, Division of Nursing
4. Esther Kwinga - Reproductive Health Coordinator, Division of Nursing
5. Janet Mwamuye – Registrar, Nursing Council of Kenya
6. Pamela Lynam - Country Representative, JHPIEGO
7. Nancy Toroitich - Program Manager, JHPIEGO
8. Dorothy Andere - Training Coordinator, JHPIEGO
9. Tamara Smith, former Country Representative, JHPIEGO
10. Theodora Bwire - Program Officer, AVSC
11. Pauline Muhuhu - Regional Coordinator, INTRAH/PRIME
12. Rose Wahome - Project Coordinator, INTRAH/PRIME
13. Florence Githiori - Project Coordinator, INTRAH/PRIME
14. Collette Aloo-Obunga (IPAS) - Training Coordinator, INTRAH/PRIME
15. Rosanna Simwa - Assistant Program Officer, FPAK
16. George Muriithi - Program Officer, FPAK
17. Veronica Musembi - National Sales Manager, PSI
18. Dorothy Hodson, PSI
19. Judy Kunyiha-Karogo - Female Hormonal Project Coordinator, PSI
20. Sheila Embounou - Reproductive Health Program Officer, UNFPA
21. Charlotte Larsen - Junior Program Officer, UNFPA
22. GTZ (interviewed by Helena Kithinji)

PARTICIPANTS IN FOCUS GROUP DISCUSSIONS

Child Survival Focus Group Participants

1. Sarah Jones, APHIA Review Consultant
2. Neen Alrutz, USAID/OPH
3. Leo Roozendal, CARE
4. Jennifer Overton, CRS
5. Victor Masbayi, USAID/OPH
6. Mary Ettling, AID/W
7. Barbara Dickerson, APHIA Review Team
8. MOH/Nutrition
9. MOH/DPHC

Health Sector Reform Focus Group Participants

1. Ian Sliney, MSH/AFS Project
2. Dr. Alberto Gallachi, HEASSP/MOH/DANIDA
3. Peter .M. Nyarang'o, HESSP/MOH
4. Stephen Mucheke, FPAK
5. George Muriithi, FPAK
6. Karanja Mbugua, World Bank
7. Barbara Dickerson, APHIA Review Team
8. Wacuka Ikua, World Bank – Nairobi
9. Roberto Esposito, E.C. Delegation
10. Josephine Ojiambo, Aga Khan Health Service
11. Emma Njuguna, USAID/ PH
12. Milly Howard, USAID/ PH

IEC Focus Group Participants

1. Joe Muriuki - Know AIDS Society
2. Michelle Folsom - KB STD Project/NASCOP
3. Gordon Nyanjom - JHU/PCS
4. John Berman - PSI
5. Barbara Dickerson - APHIA Review Team
6. Neen Altruz - USAID/Kenya
7. Dana Vogel - USAID/Kenya
8. Jane Gitonga - MoH (DPHC)
9. Jerusha Karuthiru - USAID/Kenya
10. Peter Kibiriti - APHIA Review Team
11. Dr. C. N. Kamau - BAT (K) Ltd
12. Janet Hayman - USAID/REDSO
13. Prof. G. N. Lule - University of Nairobi
14. Stephen Mucheke - FPAK
15. Esther Gatua - KANCO

Reproductive Health Service Delivery Focus Group Participants

1. Irene Mwaponda Pathfinder International
2. Pamela Onduso Pathfinder International
3. Kimeli Chepsiror NCPD
4. Ian Askew, Population Council
5. Stephen Mucheke, FPAK
6. Charles B.D. Nyaberi, Marie Stopes Kenya
7. Dorcas Amolo, Maendeleo ya Wanawake
8. Scott Radloff, USAID
9. Emma Njuguna, USAID
10. Tim Takona, USAID
11. Maureen Kuyoh, FHI
12. Donald W. Dickerson, Futures/DFID
13. Dr. Margaret Makumi, MOH/DPHC
14. Malaika Imani, PSI

Training Focus Group Participants

Facilitators: Sarah Kaviti, Melinda Wilson and Liz Kizzier

1. Dr. Job Obwaka - AVSC
2. Anne K. Njeru - MOH/SIDA
3. Peris Muriuki - MOH/UNFPA
4. John Baptist Muchiri - Clinical Officers Association
5. Tamara Smith - ex JHPIEGO
6. Jane Gitonga - MOH/DPHC
7. Pamela Lynam - JHPIEGO
8. Nancy E. Williamson - FRONTIERS Project (Pop Council/FHI)
9. Pauline Muhuhu - INTRAH/PRIME
10. Joyce Musandu - University of Nairobi/Department of Nursing
11. Robert Osiemo - Clinical Officers Council
12. Barbara Dickerson – APHIA Review Team
13. Dana Vogel - USAID/Kenya

CONTACTS FOR FIELD VISITS

Busia/Kakamega

Kakamega Provincial Health Management Team
1. Dr. Quido Ahindukha, Medical Officer of Health
2. Ms. Veronica Okoti, Provincial Matron
3. Mrs. Washika, District Public Health Nurse
4. Mr. Clement Were, District Health Education Officer/DASCO
5. Mr. George Lipesa, In-Charge, MCH/FP
6. Ms. Grace Mokune, KRCHN, MCH/FP
7. Mr. James Kuya, Records Officer
8. Mr. Jackson Shiyuka, District PH Officer

DHMT, Vihiga
9. Ms. Joyce Lungaphar, District Public Health Nurse
10. DPHO

Family Planning Association of Kenya, Kakamega
11. Ms. Henrietta Windindi, In-Charge
12. Mr. Geoffrey Menego, Manager, Male Clinic
13. Mr. Masibo Wamalwa, Field Coordinator
14. CBD Agents, FPAK CBD

Busia DHMT
15. Dr. Dickson Ombima, Medical Officer of Health
16. Mrs. Okumu, Hospital Matron
17. Mrs. Oboya, Deputy District Public Health Nurse
18. Mr. Sirigwa, In-Charge, MCH/FP
19. Mr. Wesonga, Nursing Officer, MCH/FP
20. Mr. Otonyo, Nursing Officer, MCH/FP
21. Gekonge Gesage, District Social Development Officer

Matayos Health Center, Busia
22. Rukia Kaseke, ECHN
23. Christine Ojiambo
24. Jacob Asangai

Bungoma DHMT
25. Dr. Robert Ayisi, Medical Officer of Health
26. Mr. Hezron Ngugi, BDI Project Manager
27. Mr. Sam Mukoma, BDI Deputy Project Manager
28. District Health Management Team
29. Mr. Simon Danda, Health Education Officer, DASCO/PHC
30. Mr. James Nakitare, District Public Health Nurse
31. Terrie Wafwafwa, Nutrition Advisor
32. Hasea Orone, Clinical Officer

Lugulu Friends Hospital
33. Mr. Mukasa Onyango, Hospital Administrator
34. Ms. Esther Ahono, In-Charge, MCH/FP
35. Ms. Mary Nasimiyu, KECN/FP

Webuye District Hospital
36. Ms. Prisca Nyanguka Odityo, Matron
37. Mr. Kwoba, PH Officer

AMREF
38. Mr. Hezron Ngugi, BDI Project Coordinator

Kisumu/Siaya

PHMT - NYANZA
1. Dr. Misore, Provincial Medical Officer
2. Dr. Muzore, Acting Medical Supervisor, Nyanza Provincial Hospital

GTZ
3. Dr. K. M. Ongwae
4. Njeri Mukoma

KENYA FAMILY HEALTH PROGRAM
5. Dr. Mike Adelhardt

Maseno University
6. Immanuel Aballa, Student Member of Maseno University Peer Educators Club
7. Pauline Masitsa, Student Member of Maseno University Peer Educators Club

CDC/KEMRI
8. Bernard Nahlen
9. Penny Phillips-Howard
10. Feiko ter Kule

Siaya DHMT
11. District Officer
12. Dr. Sam Ochola - MoH
13. Dr. Ibrahim Shivalo - Hosp Superintendent

TING'WANGI HEALTH CENTRE - SIAYA
14. Consolata Ochieng - In Charge
15. Albert Nyakina - Committee
16. Wekano Onjoma - Chairman

NATION - KISUMU
17. Churchill Otieno

ACK MASENO WEST
18. Bshp. Joseph Wesonga

FPAK - KISUMU
19. Nzioki Kingata - Reg. Coordinator
20. Sister Joan Oduori - Sister In-Charge

PSI
21. Jenifer Matiku

KENYA FREEDOM FROM HUNGER COUNCIL
22. Joseph Kiprono Cheruiyot

CARE KENYA
23. Programme Officer for EU-FHP

MARIE STOPES (KSU MATERNITY & NURSING HOME)
24. Dr. Peter Waweru
25. Mr. Richard Olewe

Mombasa/Tiwi/Kwale

Provincial Medical Office
1. Dr. John Adungosi, Deputy PMO
2. Mr. Macharia, Provincial Health Administration Officer

Kepi Depot
3. Mr. Komora, In-charge

Provincial Commissioner Office
4. Mr. Lims, Provincial Commissioner

Coast Provincial General Hospital
5. Dr. Esther Getambo, Chief Administrator
6. Mrs. Wamugunda, Nurse/Counselor Out-Patient Clinic
7. Mr. Reynold Haro, Social Worker/Counselor
8. Mrs. Catherine Mkanyika, Health Education Officer
9. Mrs. Ali, In-charge, MCH/FP

DTC/MTC/Preceptor Focus Group at CPGH
10. Flora Ali - DTC Coordinator
11. Jasper Mbungu - MTC Tutor
12. Naomi Ndaa - MTC Tutor
13. Lily Oyangi - Nurse Trainer/Preceptor
14. Jephris Omuka - PAC/Preceptor
15. Susan Mbunda - Nurse MCH/FP/Preceptor
16. Susan Ngwai - Maternity/Preceptor

DHMT, Mombasa

17. Dr.Chidagaya Jamanda, District Medical Officer of Health, Mombasa
18. Mr. S. M. Mwota, District AIDS/STD Coordinator (DASCO), Mombasa
19. Mrs. Agatha Ruria, District Health Education Officer

Kenya Ports Authority

20. Sister Mohammed, Matron, Kenya Ports Authority Clinic
21. Dr. Kahone, Chief Medical Officer, Kenya Ports Authority Staff Clinic
22. Hassan Obare, Peer Educator
23. Mary Njeri Gacheru, Container Terminal Clerk, Peer Educator, KPA
24. Patrick Angira, Peer Educator
25. Beatrice Lundi, Peer Educator
26. Beatrice Wekotto, Peer Educator
27. John Sakwa Obwirio, Peer Educator

Eleka Counseling Centre , Mombasa

28. James Muievu
29. Nellie Kigondu

COBA Development Agency, Mombasa

30. Alexander Kalama

Staff Dispensary, Bamburi Cement, Mombasa

31. Mrs. Mwambanga, Nurse/Peer Educator
32. Leo Mabaji, Peer Educator
33. Gladys Kimayu, Peer Educator

SWAAK, Mombasa

34. Mwana Suleiman, TV Producer, KBC Msa
35. Rose Ochieng
36. Maggie M. Mutungi
37. Jane Jilani, Program Officer, NCCK, Director, Eleka Trust, Chair, SWAAK

FPAK, Mombasa

38. Filberts Oluoch
39. Margaret Beja, Sub-Regional Manager
40. Mr. Kimeu, Clinic In-charge
41. Juma Mwatsefu, Youth Clinic Coordinator

Women's Network Center, Mombasa

42. Ame Mbogholi

K- Map/KBPWC, Mombasa

43. Mary Stevens, Regional Manager

Artnet Waves Communications, Mombasa
44. Maryrose Ikumi
45. Gathecha Kamau

Plan International, Mombasa
46. Genya Nyalie, Program Manager

Tototo Home Industries, Mombasa
47. Beata K. Mbok, Exec. Director

DHMT, Kwale
48. Dr. Tsuma and Kwale District DHMT

Mkomani Clinic
49. Mrs. Anjarwallah - Director
50. Shakeel Rahemtula - Project Manager
51. Stella Kilalo - Community Nurse

Aga Khan Health Services
52. Mr. Salim Sohani, Director
53. Henry Nyamu, Project Coordinator

Tiwi Rural Health Training Center Team
54. Mr. Mutinda, Clinical Officer
55. Halima Mwagutsi, Deputy Matron

AMREF
56. Mrs. Margaret Mwiti, Kaloleni RH Care Program, Kilifi
57. Mrs. Margaret Nyoka, Kaloleni RH Care Program

Nyeri/Murang'a

Provincial Health Management Team
1. Dr. Eliud Mwangi, PMO
2. Dr. Eliud Ritho, Deputy PMO/Provincial Pediatrician
3. Mr. Joshua King'ori, Provincial Public Health Officer
4. VM Karioki, Provincial Personnel Officer
5. Ruth Macharia, Provincial Nursing Officer
6. Karuga Karioki, Provincial Health Education Officer
7. Charles Chiuri, Provincial Health Information System
8. Cyrus Kagathi, Provincial Hospital Secretary

Provincial Hospital
9. Anne Nzimbi, Nurse/Administrator
10. Dr. Githiru - Medical Superintentent/ Regional RH Supervisor
11. Rose Gichuki - FP Coordinator/Trainer

12. Gladys Muthengi - FP Trainer (OJT)
13. Martha Muriithi - District Supervisor
14. Jedidah Ndegwa - Nurse/AVSC Coordinator
15. Lucy Mwogo - In-charge Maternity Unit/FP Trainer (OJT)
16. Naomi Kituku - Nursing Officer
17. Penina Ndegwa - Nurse Tutor
18. Ruth Macharia - Provinical Nursing Officer
19. Humphrey Kariuki - In-charge Psychiatric Unit/Continuing Education Coordinator
20. Mrs. Charity Njoki Kimotho, Teacher Counselor with youth, In and out of Sch

Karatina Municipality
21. Mr. Josephat M. Murai, Public Health Technician
22. Mr. Anthony M. Gateru, Public Health Technician

Cheru/Kiangararu Sub-Location
23. Wilson Kibethi Muriuki, Asst. Chief

Karatina Hospital
24. Robert K. Gatheri, Nurse/Counselor
25. Samwel M. Kimiruh, KRCHN/HIV/AIDS Counselor
26. Teresa Mugambi, OJT Trainer
27. Mary Murithi, Public Health Nurse/In-charge MCH
28. Lucy Gichuki, Deputy District Public Health Nurse

Karatina Home Based care & Counseling Clinic
29. Peter Njuguna Mohamed, Project Director

Karatina Maternity Home
30. Sr. Lawrenzia Njoki, KECHN

Othaya Sub-district Hospital
31. Rose Miriti, Family Planning Nurse

Murang'a District Hospital
32. Dr. Peter Ndegwa - MOH
33. Mary Wanjora - OJT Trainer
34. Mary Njoroge - DTC Coordinator
35. Tabitha Gathitu - DPHN
36. Margaret Macharia - Nursing Officer In-charge
37. John Wachira - Hospital Accounts Officer
38. Mary Chege - DTC trainer
39. Elizabeth Gitau - Principal Nurse Tutor

Marie Stopes, Murgang'a
40. Mr. Saldi, Clinic Coordinator

STAKEHOLDER MEETING – 27 APRIL 1997

PARTICIPANT LIST

	Name	Title	Organisation
1	A.S. Miheso	CDD/ARI Propogramme Officer	Ministry of Health
2	Alberto Gaclaccii	CTA	HESSP/MOH
3	Alfred Maisiba	Operations Manager	KEPI
4	Aloys Ilinigumugabo	CAFS MTR Coonsultant	CAFS
5	Angeline Tennah	Country Co-ordinator	Policy Project/ Kenya
6	Barbara Dickerson	APHIA Mid-Term review Team	
7	Benta Shako	Nutritionist	DPHC/MOH
8	Charles Thube	Country Representative	Pathfinder
9	Christiane Adotevi-McWest	CAFS MTR Manager	CAFS
10	Dana Vogel	Chief, OPH	USAID Kenya
11	Daniel Mbiti	Consultant	
12	David Kavite	Programme Administrator	JSI
13	Dorcas Amolo	Programme Manager	MYWO
14	Dr. Emily Obwaka	Resident advisor	JHU/PCS
15	Dr. Esther A. Ogaru	Youth and HIV/AIDS Programme Co-ordinator	MOH/NASCOP
16	Dr. George Muriithi	Programme Officer	FPAK
17	Dr. Joseph G. Karanja	Chairman/Project Director	Department of OB/GYN University of Nairobi
18	Dr. Margaret Makumi	RHP Manager	MOH/DPHC
19	Dr. Mike Adelhardt	KFHP Programme Co-ordinator	EU/DFID/GTZ
20	Dr. Pamel Lynam	Regional technical director	JHPIEGO
21	Dr. Pape Syr Diagne	Director	CAFS
22	Elizabeth Ewing	Econ/EST Officer	US Embassy
23	Emma Njuguna	Project Manager	USAID
24	Esther Gatua	Programme Officer Policy	KANCO
25	Esther Ndiang'ui	Financial Analyst	USAID
26	Ezekiel Kalaule	Chief prgramme Officer	CAFS
27	G. Wcyt	Economic advisor	KIPPRA/MPND

	Name	Title	Organisation
28	Helena Eversoke	Program Co-ordinator	UNICEF
29	Helena Kithinji	CAFS MTR Consultant	
30	Hezron Ngugi	Project Manager	AMREF
31	I.M. Abdille	US/Head of DHCF MOH	MOH
32	Ian Askew	Associate Director for Africa	Frontiers, Population Council
33	Ian Sliney	Chief of Party	MSH
34	J.M.K. Kangethe	Desk Officer USAID	Ministry of Finance
35	Janerose Ochola	Project Assistant	CAFS
36	Janet Hayman	TAACS	USAID/REDSO
37	Janet Mugo	Senior Assistant Secretary	MOH/DHCF
38	Jerusha Karuthiru	Project Management Specialist	USAID Kenya
39	Jessica Price	Country Director HIV/AIDS Department	FHI
40	Jock Conly	Director	USAID
41	Joe Muriithi	Chairman	NEPLHAK
42	John Berman	Country Rep	PSI
43	John Wilson	Advisor/COP	JSI/FPLM
44	Joseph Ondigi	Financial Analyst	USAID
45	Josephine Ojiambo	Project Development	Aga Khan Society
46	Julius Kadima	Schools Health Co-Ordinator	FHIK
47	K. Gopala	KFW Consultant	KFW
48	Karuga Kiragu	Associate	JHU/PCS
49	Keith A. Edwards	Associate Director	AVSC International
50	Liz Kizzier	Pop. Fellow	USAID
51	Lucy Mogeni	Administrative Assistant	USAID
52	Lucy Mugweru	Administrative Assistant	USAID
53	Margaret Muiva	Chairman, Nursing Services	University of Nairobi
54	Mary T. Mujomba	CAFS MTR Facilitator	CAFS
55	Mary Ogutha	Secretary	CAFS
56	Melinda Wilson	Regional RH and Child Health Advisor	REDSO
56	Michael Welsh	Regional Director	FHI
57	Michelle Folsom	Technical Advisor	REDSO

	Name	Title	Organisation
58	Mike Strong	Senior RH Advisor	USAID Kenya
59	Milly Howard	Senior Health program Advisor	USAID
60	Mr. Charles Nyaberi	USAID Project manager	Marie Stopes Kenya
61	Mr. Omondi Ochola	Assistant Secretary	MOH/DEV
62	Mr. Zablon O. Barake	Clinical Officer	MOH Headquarters
63	Muthoni Kariuiki	Project Manager	AMREF
64	Nancy Toroitich	Senior Training Co-ordinator	JHPIEGO Corporation
65	Naomi Blumberg	Senior Technical Officer	USAID Washington
66	Neen Alrutz	TAACS	USAID
67	Nyanjom	IEC Officer	KB STD/NASCOP
68	Paul Kizito	Assistant Director	NCPD
69	Peter Kibiriti	CAFS MTR Consultant	Corporate Africa Ltd.
70	Peter Mwarogo	Programme Officer	FHI
71	Richard Odindo	NGO/Training Co-ordinator	Futures Group International
72	Rose Wahome	Program Officer	INTRAH/PRIME
73	S.N. Wainaina	Planning Manager	Kenyatta National Hospital
74	Sarah Jones	CAFS MTR Consultant	
75	Sarah Kaviti	CAFS MTR Consultant	
76	Stephen Mucheke	Assistant Programme Manager	FPAK
77	T. Mboya Okeyo	World Bank STI Project Co-ordinator	MOH/NASCOP
78	Tabitha M. Oduori	Family & RH Programme Officer	WHO
79	Timothy Takona		USAID
80	Victor Masbayi	Program Officer Child Survival	USAID
81	Wacuka Ikua	Operations Officer	World Bank
82	Willie Nyambati	HPO	JICA

ANNEX D: OVERVIEW OF MTR SCHEDULE

Week 1-3 Team leader in place, consulting with staff from the Office of Population and Health on key issues and questions, organizing a library of materials, providing input in hiring of consultants. Core technical teams are constituted.

End week 3 Consulting firm and team of five consultants hired.

Week 4 Two day orientation and team building session which included team leader, five consultants heading up core technical teams and OPH staff. Meetings included presentations on structure of the APHIA project, mechanisms for APHIA project funding, project management and roles and responsibilities of various offices within the USAID system.

Week 5-6 With participation from OPH staff, consultants conducted desk research and key informant interviews in Nairobi

Week 7 Team members from REDSO/ESA and AID/W joined review in progress. All team members participated in two half-days of orientation and team-building. Week ended with half-day focus group discussions for each major issues area plus a half-day discussion among USAID staff on implementing mechanisms.

Week 8 Field visits. Four interdisciplinary teams comprised of members drawn from each of the core technical areas conducted three days of field work at four sites around the country: Busia/Kakamega, Kisumu/Siaya, Nyeri/Murang'a and Mombasa/Kilifi/Kwale.

End week 8 Two day team synthesis meeting at the Mt. Kenya Safari Club

Week 9 Stakeholders meeting. Originally planned to be a full day, time was reduced to a half-day, allotting approximately one half-hour for welcome and introductions, one hour for presentation of major accomplishments, findings, conclusions and recommendations. The remainder of the morning was spent in small group discussion of reactions to the presentation and group recommendations. The briefing of USAID mission staff did not take place during this week as planned.

Week 9-10 Consultants drafted issues papers

Week 11-12 Team leader reviewed issues papers, OPH and REDSO/ESA staff provided assistance with reviewing and editing. Team leader drafted final report.

Week 13 200 copies of final report printed and distributed.

ANNEX E: LESSONS LEARNED FROM THE MTR PROCESS

Most of the comments below flow out of a discussion among members of the extended review team which took place immediately following the stakeholders' meeting.

- Hiring the team leader independently through direct contract to USAID helped to ensure that USAID maintained a significant degree of control over the review process. The team leader worked mainly from the OPH offices during the entire process up through the end of the field work and team synthesis. The team leader functioned as a bridge between the OPH perspective and the independent perspective and analysis provided by the consultants.
- There was insufficient understanding at the outset of the energy and time that would be required to organize a team of approximately 25 individuals which was reconfigured from time to time into four different groupings. This led to difficulties with time management in meetings and slowed the pace for the investigative and analytical process.
- Momentum in the review process slowed when attention had to be diverted mid-way to absorbing team members from REDSO and AID/Washington who joined the process mid-way. Changing the timing for participation from AID/Washington was not possible; however the team felt that their participation was critical. Participation of REDSO members would have been strategically more valuable had they been booked for the week during which orientation and team building took place and for the two weeks during which the focus groups, field trips and team synthesis took place.
- On a similar note, some key OPH staff members were missing during the critical first two weeks after the local consultants had been hired when their input was needed to shape the direction of the investigation and analysis.
- Field trips could be much better planned and organized in the future. It was not necessary to wait until the consultants had been hired to begin identifying sites and making the necessary contacts. Two weeks was insufficient lead time for planning and notifying contacts. The team agreed that one month's lead time is essential. The team also noted that expectations of what could be accomplished during field visits was too high. Each field team accomplished much less than what had been planned. Nevertheless, the group generally agreed that the impressions from the field trips were extremely helpful in refining their analysis around the main issues for each core technical area. The group also agreed that the visits during the field trips adequately covered topics and organizations of essential interest.
- Despite constraints mentioned above the group agreed the quality of teamwork among the core technical teams was quite high.

ANNEX F: TERMS OF REFERENCE FOR TEAM LEADER

TERMS OF REFERENCE MID-TERM REVIEW
AIDS, POPULATION AND HEALTH INTEGRATED ASSISTANCE PROJECT

I. Introduction

The AIDS, Population and Health Integrated Assistance (APHIA) Project was designed to consolidate, focus, and rationalize all USAID support to the population and health sector in Kenya. APHIA was approved in August 1995 as a five-year, $60 million results package. In January 1999, APHIA was extended at a level of $135 million over 10 years. The purpose of the project was identical to the Mission's Strategic Objective #3 (SO#3) *to reduce fertility and the risk of HIV/AIDS transmission through sustainable, integrated family planning and health services*.

USAID/Kenya believes that significant progress has been made under the APHIA project. The 1998 Kenya Demographic and Health Survey (KDHS) shows that the impressive reduction in fertility is continuing. The total fertility rate in Kenya has dropped from eight in the late 1970s to 4.7 by 1998. Most of this decline was due to the increased use of modern family planning methods by Kenyan couples. Among currently married women, the contraceptive prevalence rate (CPR) for modern methods has increased to 31% in 1998, up from 7% in 1977. Condom sales increased dramatically in 1998 and important AIDS policy issues are beginning to be addressed.

However, the KDHS shows that important challenges remain. Kenya still has a large unmet demand for family planning services and existing services are not evenly distributed throughout the country. HIV/AIDS also presents a major challenge to Kenya's health, economic, and social sectors. Adult HIV seroprevalence has risen from 3.5% in 1990 to more than 9% in 1998. Finally, after decades of decline, child mortality is beginning to rise, probably due to malaria and AIDS and to problems in the delivery of health care.

As APHIA enters its fourth year, it is timely to review progress toward its objectives and suggest any adjustments that may be required. Therefore, USAID/Kenya will conduct a mid-term review (MTR) of the APHIA results package during March and April, 1999.

II. Background

USAID has supported Kenya's family planning program since 1972. By the mid-1980s USAID was the lead donor, providing an average of $17-$20 million annually through bilateral and central projects. During the early 1990s, USAID continued to be the lead donor in family planning and provided one-quarter of HIV/AIDS prevention program expenditures. It was also the largest source of support to the national health care financing program. Through 1994, USAID/Kenya's health and population program consisted of four bilateral projects, 15 contracts and cooperative agreements with U.S. organizations, and sub-grants with 25 Kenyan NGOs and 41 private sector organizations.

In 1994, USAID/Kenya began the design of the five-year $100 million APHIA project. However, in 1995, as APHIA design was nearing completion, USAID/Kenya received sharp budget cuts which required the Office of Population and Health (OPH) to develop both high ($9.3 million)

and low ($6.3 million) budget scenarios. Under both scenarios, explicit support to family planning service delivery, as well many other program elements, including research, IEC, the district focus, and the HIV/AIDS program, was dramatically reduced. In reaction to these cuts, USAID elevated its emphasis on sustainability. Sustainability was defined in APHIA as "support to strategies and programs which build Kenya's capacity to sustain health and family planning services and meet *future* needs with local resources." Four years later, in 1999, annual funding levels are about $12 million, but the decision to invest more heavily in sustainability has not been explicitly revisited.

Many of USAID's cooperating agencies (CAs) providing technical assistance in Kenya under the previous bilateral project continued to undertake similar activities under APHIA. USAID would like to review their direction and accomplishments, and examine implementation and management options, before providing further support.

There are a number of new program areas which USAID/Kenya should perhaps consider. The 1998 KDHS has recently raised concerns about child survival and infectious diseases. There are also new opportunities to promote or socially market more effective family planning methods and other commodities. In addition, there is increased impetus to focus on adolescent reproductive health, postabortion care, Vitamin A, or female circumcision. The MTR team should look carefully at these areas and recommend strategies and programmatic adjustments for USAID, if appropriate.

In HIV/AIDS, new directions have already been proposed. An HIV/AIDS strategy was completed in 1998 and will be implemented in 1999. The MTR will be beneficial in affirming the appropriateness of new activities within the overall program. Other activities such as social marketing and logistics management are felt to be essentially on track and should continue with their current strategies with, perhaps, modest adjustments to be proposed by the MTR team.

Overall, therefore, it is timely for USAID/Kenya to review APHIA's original assumptions, its progress toward objectives, and recommend any changes, if necessary.

III. Objectives of the review

A. Purpose

The specific purposes of the MTR are:

a) To review and assess the investments and accomplishments of APHIA to date.

b) To make recommendations about modifications, if any, which are warranted for the next six years of APHIA.

c) To increase the awareness and local ownership of APHIA through sharing and requesting feedback on the hypotheses, findings, and recommendations of the MTR team through a series of focus groups and stakeholders' meetings.

It is not expected that the recommendations of the MTR team will propose to change the overall strategic objective of SO#3 to *reduce fertility and the risk of HIV/AIDS transmission through sustainable integrated family planning and health services*. Nevertheless, based on the MTR, the SO#3 team will be prepared to consider any recommendations or issues concerning the language, content, linkages, or direction of the intermediate results, sub-intermediate results, and activities.

B. Detailed issues papers

Descriptive papers will be written on many aspects of APHIA, although not all elements will be reviewed at the same level of detail. The issues proposed for consideration in greater detail grew from a series of discussions held within the SO#3 core team about what needed to be better understood or clarified prior to continuing the implementation of APHIA. The elements proposed for the detailed issues papers include: family planning service delivery; training; IEC; child survival; and health sector reform. A number of cross-cutting issues were also identified. These should be addressed within each issues paper.

1. Family planning service delivery

The nature of USAID support to family planning service delivery as well as the level of that support has changed over time. Before 1995 the traditional focus was on subsidization of the direct cost of FP services to meet current demand for family planning, especially through support to community-based distribution (CBD) activities. USAID now supports a broader range of reproductive health activities. Some CBD activities have been cut back while new, clinic-based services have been developed. The implications of these changes are not completely clear and should be examined in the course of the MTR. The team should:

- Review the family planning service delivery activities that USAID is supporting under APHIA and assess their impact.

- Given USAID's funding levels, manageable interests, and Kenya's national needs, propose a rationale for continuing or changing APHIA's decision to reduce USAID's explicit support for service delivery.

2. Training support for service delivery

Under APHIA, USAID's support to training was intended to work with the Ministry of Health (MOH) to improve the management of the training facilities at both the central and regional level, to consolidate and integrate reproductive health training, and to improve the efficiency and cost effectiveness the MOH in-service training programs. In addition, it was proposed to revitalize the MOH’s Rural Health Training Centers or the Medical Training Colleges. Finally, the Division of Primary Health Care (DPHC) and the Department of Nursing were to have jointly established a formal structure and regular activities for district and sub-district supervision of family planning and reproductive health activities.

In addition to APHIA's explicit training component, most CAs undertake many other training activities. These include training of social marketing sales persons and private sector providers; training geared to quality and management improvements; and training in counseling, STD diagnosis and treatment. A summary of these activities should figure in the overall review of training. Therefore, the team should:

- Review the training activities that USAID had supported under APHIA and the support given by other donors and assess the degree to which they are complementary and respond to national needs.

- Given USAID's funding levels, manageable interests, and Kenya's national needs, propose a rationale for continuing or changing APHIA's approach to training.

3. IEC support for service delivery

Before APHIA, USAID's IEC activities were focused on development of provider materials and the launch of a national IEC campaign with a family planning theme. With the decreased resources available under APHIA, the key CA providing IEC services, Population Communication Services (PCS) was scheduled to be phased out in 1997-98. Therefore, beginning in 1995, greater emphasis was to have been placed on institution building and sustainability activities necessary for the development of a coherent national IEC program. These activities included: strengthening mechanisms and structures for development of a national IEC strategy and coordinated implementation; providing technical assistance (TA) and services to planners and implementors to develop effective IEC messages and campaigns; and assisting a Kenyan institution develop the capacity to become a lead technical resource to planners and implementors of IEC programs. In addition, the development and launch of a FP logo was a key objective for the program.

For a variety of reasons including, but not limited to diminished USAID resources, these activities have met with limited success. Therefore, the MTR team should undertake the following:

- Review the IEC activities that USAID has supported under APHIA and assess the degree to which they are responding to the national needs.

- Given USAID's funding levels, manageable interests and Kenya's national needs, propose a new rationale for IEC under APHIA.

4. Child survival

The original five-year $100 million APHIA project had a district focus element that proposed to "assure implementation and evaluation of an integrated package of services to ensure the quality and efficiency of curative and preventive care for sick children." When funding for APHIA was halved, the district focus was eliminated. It was reinstituted thanks to Africa Bureau funding through the *Africa Integrated Malaria Initiative* (AIMI) that focused on malaria prevention in young children and pregnant women. Similarly, since 1995, funding from Bureau for Humanitarian Response/Office of Private and Voluntary Cooperation (BHR/PVC), the Africa and Global Bureaus, and the Regional Office for East and Southern Africa (REDSO) has made possible a variety of child survival, nutrition, food security, and infectious disease interventions throughout Kenya.

The 1998 KDHS showed that child mortality rates are increasing. There are increased numbers of children becoming HIV positive through vertical transmission, increased numbers of orphans and street children, and concerns about food security in Kenya and the region. Together these raise questions about the possible need to broaden the relative emphasis on child survival under APHIA. Therefore, the MTR team should:

- Review the activities which are being undertaken through a variety of USAID funding mechanisms in child survival in Kenya.

- Clarify APHIA's original approach to child survival and outline USAID's comparative advantage in selected child survival interventions.

- Propose, if appropriate, a rationale for unifying these various activities into a set of focused interventions that conform to the original intentions set forth in the APHIA results framework and suggest a role for USAID considering ongoing activities, management burden, funding, and other issues.

5. Health sector reform

A key assumption of the USAID strategic plan for APHIA is that "the GOK will implement policies articulated in the l994 Health Policy Framework." Reforms, as spelled out in the Framework, are concerned with improving the quality and equity of access to health care -- issues that are of cross-cutting concern to USAID's developments in the sector. The GOK envisions that more rational and efficient programming and management of sector resources will be key to reforms. The GOK's tools for implementing reforms include: (1) structural and organizational changes; (2) progressive policies and legislation; (3) effective management follow-through; and (4) coordination with donor partners who contribute substantially to financing and technical direction of the sector.

OPH has three Intermediate Results (IRs) under its SO. IR#1 is concerned with all four elements of the GOK's reform agenda. A key issue for the MTR team will be to assure that the objectives and sub-results proposed under IR#1 are framed correctly and are within USAID's manageable interest. Specifically, the MTR team should:

- Review progress to date in the four key areas of: sector structural change, policy advances, management improvements and donor coordination.

- Propose modifications, as appropriate, in the OPH approach to assisting the GOK in its policy reform efforts.

- Make recommendations, as indicated, for recasting IR#1 results and sub-results to better reflect the assistance efforts of USAID in the area of reforms.

C. Other issues papers

In addition to the focus issues outlined above, other key elements of APHIA will be reviewed during the MTR. Short summaries of each will be prepared through desk reviews and discussions with CAs, the MOH, and other stakeholders. These summaries will outline progress to date and elucidate issues that need to be addressed in the future. The issues which will be addressed in shorter summary or review papers (to be prepared as part of the desk review) include: logistics, social marketing, the HIV/AIDS program, and the APHIA finance and sustainability (AFS) contract.

D. Cross-cutting issues

A number of cross-cutting issues were also raised by the SO3 team. These should be addressed within each major and minor issues paper. They include: policy, adolescents, gender, research, sustainability, project management options, quality improvements, and regional focus.

IV. Requirement

USAID/Kenya requires assistance to undertake a series of activities that will result in a document which reviews the accomplishments of APHIA. The final document will make

recommendations about future directions that would make APHIA more effective in reaching its objectives.

The review will be fully collaborative, drawing on opinion and expertise from Kenyan health professionals, technical staff from USAID/Kenya, REDSO/ESA and USAID/Washington's Africa and Global Bureaus. In addition, partners from the MOH, non-governmental organizations (NGOS), CAs, other donors and the private sector will be involved throughout the process.

A MTR team, composed of the team leader, local technical consultants, staff from USAID/Kenya, REDSO and USAID/Washington will be responsible for undertaking the assessment and producing the final MTR document. The SO#3 core and expanded teams will participate in selected activities throughout the review process.

The members of the MTR team will undertake the following activities:

A. Prepare issues papers

For each of the priority topics identified in Section III (above), a sub-team will work together to prepare an issues paper. A detailed outline for the issues paper will be provided to each sub-team. In general, each issues paper will describe USAID interventions and how they are meeting the identified needs. It will review the gaps and constraints and will specify the kinds of additional technical assistance or other support needed to carry out these activities. It should address key on-going and emerging issues within each intervention, making recommendations to USAID concerning each. Each sub-team will be made up of a local technical consultant, an OPH staff member, and REDSO or USAID/Washington technical experts, as available. The sub-teams will undertake the following activities:

a) Meet with USAID/Kenya staff to clarify mission perspectives, activities and priorities under the APHIA project.

b) Conduct a desk review of all relevant APHIA documents pertaining to the priority topic. This will include documents such as relevant agreements and work plans with the implementing organizations; assessments, evaluations or research relevant to the activity area; and recent progress and quarterly reports from the relevant implementing organization. Other documents that should be reviewed include the APHIA project paper and amendments and KDHS reports.

c) Conduct interviews, discussions, or focus group discussions with implementing partners, MOH officials, and other appropriate people.

d) Make site visits, as appropriate.

B. Participate in a parameters-setting meeting

The MTR team will meet with the expanded SO#3 team in a parameters-setting meeting. The purpose of this meeting will be to review key elements of the issues papers prepared by the sub-teams in order to assure that the MTR team addresses all issues of concern to mission management and the expanded SO#3 team. A second purpose of the parameters-setting meeting will be to identify concerns that may not have been raised in the issues papers. Finally, the parameters-setting meeting will also clarify the processes to be used in reviewing the issues which will help all stakeholders achieve consensus on recommendations for the next six years of APHIA.

C. Participate in focus group and stakeholders' meetings

Members of the MTR team will participate in focus group discussions and a consensus-building meeting for key stakeholders. They will summarize the preliminary findings of the various issues papers, lead discussions on them and help participants come to agreement on what modifications, if any, might be recommended for the future programs of APHIA.

D. Prepare the MTR final document

The MTR team will be responsible for completion of the final MTR review document synthesizing findings and recommendations. Team members will write appropriate sections of the final report. The team leader will assign specific writing tasks to team members based on their areas of expertise.

The final document should include the following sections:

I. Executive summary
II. Background
III. Kenya country context
IV. Summary of key issues
V. Conclusions
VI. Recommendations
VII. Annexes
    A. Issues papers
    B. Bibliography
    C. List of team members and stakeholders consulted
    D. Other attachments, as appropriate

E. Present findings of MTR to mission

The team will be responsible for making a short presentation of the overall findings and recommendations to the USAID/Kenya mission management.

V. Schedule of activities (illustrative)

Feb. 15	Team leader selected
Feb. 15-26	Team leader begins organizational/logistics work; meets with OPH staff; assists in identifying local consultants and consulting firm
Mar. 15	Consulting firm with technical consultants selected
Mar. 19	MTR secretariat established
Mar. 22	Team leader, local consultants, OPH: orientation, team building, assignments, draft outline for issues papers
Mar. 23-Apr. 9	Team leader, local consultants, OPH: meet with CAs, MOH, donors, and other stakeholders
April 12-13	AID/W and REDSO team members arrive: team building, orientation, overview of APHIA, assignments)
April 14	Parameters-setting meeting with SO#3 team
April 15,16,17	In-town focus groups and meetings with selected stakeholders
April 19-22	Field trips
April 23-24	Team synthesis workshop (off-site)
April 26	Preparation for stakeholders' meeting
April 27	Stakeholders' meeting

April 28 Integration of stakeholders' recommendations into final report
April 29 Presentation of MTR recommendations to USAID mission
April 30 Editing and completion of MTR sections by team members; AID/W, REDSO and local consultants complete work and depart
May 1-15 Team leader oversees consulting firm secretariat's finalization of MTR document; reproduction and distribution to stakeholders

VI. Scope of Work: Team Leader

A short-term consultant will be recruited as team leader for the MTR. This person will have overall responsibility for the review process, including completion of the final review document. S/he will be responsible for:

- Assisting OPH in identifying local consultants and consulting firm
- Providing overall leadership and management guidance to the MTR and the various teams
- Determining and following schedules for all activities
- Conducting regular briefings for OPH management
- Reviewing all issues papers to assure technical correctness, completeness and complementarity
- Planning the issues group meetings and stakeholders' meeting
- Working with the consulting firm's facilitator and logistics staff on the design and implementation for all meetings
- Overseeing preparation, revision and distribution of all MTR documents including the final report.

VII. Level of effort

Total number of working days: approximately 65:
26 days in February and/or March, 1999
24 days in April
15 days in May, if needed, for report completion, revision and distribution.

(If an international person is chosen the starting and ending dates and schedule will be negotiated to ensure a maximum of 65 working days.)

VIII. Administrative and logistical arrangements

A. Relationships

The team leader will report directly to the Chief, Office of Population and Health. The team leader will work closely with the OPH's MTR coordinator, the local consulting firm, and the consultants and facilitator hired by that firm. As necessary, supplementary guidance will be provided by the Executive Officer, USAID/Kenya.

B. Completion of Deliverables

The contract will only be considered successfully completed when the Team Leader has accepted individual technical consultants' assignments and when USAID/Kenya has received and accepted the document described in *Section IV.D*, *Requirement*, of the Terms of Reference. Two paper copies of the final document shall be delivered to the Chief, OPH. In

addition, the team leader will submit an electronic copy of the entire document in WordPerfect 5.2 on a 3.5" diskette.

C. Office space and equipment

Prior to the establishment of a MTR secretariat by a local consulting firm (to be procured under a separate contract), the team leader will be provided with temporary work space in OPH. After the secretariat is established in April, the team leader will work there with the rest of the team. The team leader will be required to have a personal computer. No access to USAID DMB services, facilities, or staff will be provided.

D. Transport

Local transport and perdiem will be reimbursed at the USAID rate for Kenya on a monthly basis. Airline tickets will be reimbursed on a cost basis, upon submission of official receipts.

E. Workweek

A six-day workweek is authorized, without a premium payment.

F. Payment

Payment of consultancy fees will be made upon completion and acceptance of the final report.

IX. Evaluation Criteria:

- Proven management and organizational skills on project design or evaluation teams, preferably with USAID (40%)
- Strong writing and communication skills (25%)
- Technical familiarity with family planning, reproductive health and IEC programs in sub-Saharan Africa (20%)
- Seven to ten years experience working in public health programs in developing countries (15%)

ANNEX G: BIBLIOGRAPHY

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ANNEX H: REPORT OF THE STAKEHOLDERS MEETING

The APHIA Mid-Term Review stakeholder meeting was held on April 27, 1999 at Safari Park Hotel. The purpose of the meeting, attended by about 80 participants, was to disseminate the major findings that emerged during the mid-term review.

Mr. Jonathan Conly, Director of USAID/Kenya, officially opened the meeting.

Dr. I.M. Abdille, representing the Director of Medical Services Professor Julius Meme, also attended the meeting.

The Process of the Stakeholders Meeting

The meeting began with various presentations after which all participants were divided into six groups for further discussions.

Plenary presentations during the meeting covered issues on

- an overview of APHIA
- the APHIA Mid-Term Review Purpose and Process
- major Findings (accomplishments; issues; critical actions)
- the Context for Future Efforts (including a brief description of current demographic and health trends and the input of APHIA within these trends)

The group work sought to identify any issues missed, and what participants at the meeting considered to be the most important finding. Members in each group then came to a consensus on the two most important issues that could be synthesised from individual reactions, and made recommendations.

ISSUES EMERGING FROM THE GROUP WORK

Child Survival

- Significant reduction on immunisation coverage – how can this be arrested?
- How can VII help incorporate other vaccines into the programme schedule (e.g. yellow fever and hepatitis B)
- VII is actually unstable and is not successful as reported during the presentation.
- Because of the rising child mortality, APHIA should increase allocation to it.
- Nutrition as a critical issue in child survival has been missed.
- The IMCI strategy is currently only covering a few districts. Why not the whole country?
- The degree to which VII has been successful in this era of economic constraints is not clearly spelled out.

IEC

- The role of behaviour change communication (BCC) across all sectors implied but could be strengthened.
- Very interesting that condom social marketing works very well
- Use of local languages in IEC has not been fully explored. Thus, this hampers communication for the majority of people in rural areas.
- Review the National IEC plan to incorporate action-oriented research activities.
- Major focus on distigmatisation of HIV/AIDS is required
- Develop Rapid Response Capacity to counteract negative RH reports in popular media.
- There is need for IEC to be intensified – not only through radio, TV, newspapers – but down to the community level (barazas, churches, political meetings, …)

Health Sector Reform

- The presentation missed stating how to make communities own their own health and hence their health institutions
- The role of NGOs is missing yet they play a major role in health care provision
- Of critical importance is the inefficiency in utilisation of public health resources; lack of MOF commitment to identify and implement reform; the appropriate balance of public/private resources applied to curative/preventive health services; and the budget system encourages incremental approaches to resource allocation.
- Improve the MIS at the MOH – publicise findings to encourage adoption of best practice; consolidate MOH planning and HEROS units and mandate to produce a resource constrained sector plan; initiate debate on health sector resource utilisation (preferably based on National Health Accounts); encourage MOF/DPM to adopt more flexible approach to annual estimates/forward budgets

- It seems like we are over-stating the progress being made in cost sharing. There are other community financing initiatives and thus very limited "success" to date. Need for a comprehensive plan for the entire health sector reform with time line and goals to advance the introduction of successful prototypes.
- Identify gaps in district level management of health programmes and provide on-the-job training to address these gaps.
- The process of health sector reform is too slow.

Service Delivery

- In RH service delivery, only family planning was considered; other important aspects were not mentioned
- Inadequate focus on STI services accomplishments and issues
- There is need to synchronise MOH-donor approach to condom promotion.
- For RH service delivery, no mention was made of the many barriers to adolescents obtaining both information and especially services. In addition, no reference was made to the ICPD mandate of developing integrated service delivery.

Training

- Begin to integrate public/private sector training
- Interesting to note that a wide range of curricula and support materials exist for training.
- The issue of deployment really needs to be looked into
- Clarity is needed on the lack of adequately trained service providers and superiors at all levels
- What is the Training Information Monitoring System being used for currently? Where do the gaps lie?
- APHIA should support management training in medical schools, nursing schools and elsewhere.
- The presentation did not touch upon the current impact of training received.

General

- Frightening demographic trends.
- USAID seems to work best at national level. Maybe this should continue.
- A good summary of what APHIA does. However, more information from the KDHS is needed to support some of the recommendations
- After this meeting, there may be need to make a presentation to senior MOH officials/Ministry of Planning in order to get some form of commitment and work out an implementation plan.
- Together with other donors, USAID should develop a plan of action based on conditions that must first be met by the GOK/MOH. There may be need to lobby at diplomatic levels.
- After identification of critical issues in all areas, what are the next steps? My concern is more on GOK commitment to pushing issues that concern it. (e.g. critical actions under training)

- Assign more importance and allocate resources to implementing the existing adolescent RH strategy. In doing so, look beyond the public sector and ensure that efforts can be implemented at a large scale.
- Is USAID trying to do it all? And are the 50? 30? 20 the most effective use of resources? Revisit this considering USAID's competitive advantage.
- The major emphasis is on donors and GOK partnerships. The community needs to be involved as well.
- The presentation failed to emphasise that HIV/AIDS is a national catastrophe and the major cause for other problems such as economic constraints and infant mortality
- There is need for improved co-ordination with the GOK, NGOs and other private sector players for the improvement of APHIA
- How best can the MOH contribute to financial support for service delivery and training?
- How best can we link research to implementation in the five technical areas? How can the GOK assist in this?
- During the next five-year implementation period of APHIA, all CAs, NGOs and partners should build strong components on sustainability into their programmes so that by 2005 APHIA final evaluation findings reflect incountry capability to continue programmes with minimal donor support.
- There was no discussion on maternal mortality
- No adequate discussion on programme sustainability
- A lot has been achieved but it is all on the verge of being lost – need for strong leadership to counter balance this loss.
- The presentation was too HIV/AIDS/FP focused. There needed to be more stress on demographic health gains since independence (prognosis short-term)
- Appeal to donor agencies to participate fully in AIDS awareness campaigns – there is need to emphasise that AIDS knows no boundaries

GROUP ISSUES AND RECOMMENDATIONS PRESENTED TO PLENARY

Issues	Recommendations
There is insufficient acknowledgement of the economic context and structural barriers by the GOK and other donors	APHIA should define integration and articulate ways to operationalise it at various levels
Worsening trends in child survival and maternal health	Training, deployment , supervision and resource allocation should be looked at deeply
Poor utilisation of health sector resources	MOH should co-ordinate the development of a health sector plan with an implementation schedule.

Governance/government leadership is an issue – staffing turnover; morale; skills	Address issues related to governance within specific interventions, not as an overall issue – e.g. in context of RH, HIV/AIDS/CS. Address in all stages of project from design phase through implementation. Regular co-ordination/communication: technical working groups with well-defined TOR
Presentation of technical issues was vertical and we fear this reflects a lack of integration in the design resulting in vertical programmes at the field level	USAID health initiative needs to be designed to actively respond to social-economic and structural barriers to improved health (e.g. synergy with other strategic objectives and an emphasis on long-term preventive solutions including strategic communication
Insufficient attention to management development for co-ordination with MOH, donors, communities and empowerment, resource management and supervision	Provide support to management training programmes that systematically address more effective use of resources.
Concern over lack of political commitment from GOK to health (e.g. resources and ways resources are used)	APHIA to explore ways to improve commitment, both political and ministerial, to promote health and health reform in Kenya
Health reform process in question	
Presentation missed reaching the youth with IEC	Youth need to be reached using successful experiences. Youth are not homogenous (8-10 yrs; 11 – 14 yrs; 15 – 18 yrs) Create demand among youth for the right to better health Create the right environment for accessing services (parental education; policy; service provider attitudes)
APHIA currently perceived to be focusing on FP/HIV/AIDS only	APHIA should re-examine its (50; 30; 20) percentage focus on the various portion of the project.
Challenges should be addressed through programme planning, linkages and resource allocation with the reform process.	Greater attention to process, planning linkages; co-ordination; Focus on programmatic areas (with USAID manageable interests) that have greatest potential for impact (bednets; nutrition; youth; reproductive health)

Plenary discussions after the various group work revealed the following key points:

- Leadership: discussion focused on what can be done to encourage the Ministry of Health to take up leadership of the whole process since donors cannot continue to co-ordinate themselves. It was reiterated that there must be a driving force that initiates and co-ordinates all activities currently being undertaken within and by the Ministry of Health. In line with this, the point was raised that the Government of Kenya's commitment is not in doubt. All the problems currently being witnessed are largely due to the Kenya Health Care Framework, and the apparent structure of the Ministry of Health. A suggestion was made that to diffuse this, a unit should be established within the MOH as a focal point for all co-ordination issues.
- A strong recommendation was also made that USAID monies through APHIA should probably focus more at the regional rather than national level. This would go a long way in empowering communities, which may translate into project sustainability.
- Concern was also raised at the slow rate of health sector reform, and its implications on health services at the decentralised level. The serious cash flow problem at all levels of the system needs urgent attention. This cannot be the sole responsibility of USAID as a donor. Other donors, including GOK should also address this as a matter of urgency.
- The Ministry of Health must also address the issue of motivation and incentives at all levels. APHIA's role in this is currently unclear.

General Impressions of the Meeting

- Time keeping was well managed during the whole meeting.
- There seemed to have been a need for further discussions within groups. It may also have been a good idea to keep to the original idea where the major issues of child survival, IEC, health sector reform, service delivery and training determined group demarcation. A quick survey among the various groups revealed a need for some clarification on some issues presented, which could easily have been accomplished within a "major issue" group discussion.
- A general assumption was made that all who attended would automatically begin appreciating their role within APHIA. It was my impression, however, that this acknowledgement of each partner's role is seen in isolation. As a result, most stakeholders do not "own" APHIA and thus approach it from very divergent views. There is need to have all stakeholders approach this project from a holistic viewpoint. Inherent within this is the realisation that all partners form APHIA, and APHIA does not stand apart.

Report prepared by Mary Mujomba, Meeting Facilitator

May 1999